103

S. HRG. 103–658

WILL PATIENTS AND DOCTORS BE PROTECTED UNDER HEALTH CARE RERFORM?

Y 4. L 11/4: S. HRG. 103-658

Will Patients and Doctors be Protec...

HEARING

BEFORE THE

SUBCOMMITTEE ON LABOR

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

EXAMINING THE QUALITY OF HEALTH CARE THAT WOULD BE PROVIDED TO CONSUMERS UNDER A PROPOSED MANAGED HEALTH CARE SYSTEM

FEBRUARY 3, 1994

Printed for the use of the Committee on Labor and Human Resources

SUPERINTENDENT OF DOCUMENTS
DEPOSITORY
SEP 19 1994
BOSTON PUBLIC LIBRARY
GOVERNMENT DOCUMENTS DEPT.

U.S. GOVERNMENT PRINTING OFFICE

81-706 CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-044764-X

S. HRG. 103–658

WILL PATIENTS AND DOCTORS BE PROTECTED UNDER HEALTH CARE RERFORM?

Y 4. L 11/4: S. HRG. 103-658

Will Patients and Doctors be Protec...

HEARING

BEFORE THE

SUBCOMMITTEE ON LABOR

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

ON

EXAMINING THE QUALITY OF HEALTH CARE THAT WOULD BE PROVIDED TO CONSUMERS UNDER A PROPOSED MANAGED HEALTH CARE SYSTEM

FEBRUARY 3, 1994

Printed for the use of the Committee on Labor and Human Resources

SUPERINTENDENT OF DOCUMENTS
DEPOSITORY
SEP 19 1994
BOSTON PUBLIC LIBRARY
GOVERNMENT DOCUMENTS DEPT.

U.S. GOVERNMENT PRINTING OFFICE
81–706 CC WASHINGTON : 1994

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-044764-X

COMMITTEE ON LABOR AND HUMAN RESOURCES

EDWARD M. KENNEDY, Massachusetts, *Chairman*

CLAIBORNE PELL, Rhode Island
HOWARD M. METZENBAUM, Ohio
CHRISTOPHER J. DODD, Connecticut
PAUL SIMON, Illinois
TOM HARKIN, Iowa
BARBARA A. MIKULSKI, Maryland
JEFF BINGAMAN, New Mexico
PAUL D. WELLSTONE, Minnesota
HARRIS WOFFORD, Pennsylvania

NANCY LANDON KASSEBAUM, Kansas
JAMES M. JEFFORDS, Vermont
DAN COATS, Indiana
JUDD GREGG, New Hampshire
STROM THURMOND, South Carolina
ORRIN G. HATCH, Utah
DAVE DURENBERGER, Minnesota

NICK LITTLEFIELD, *Staff Director and Chief Counsel*
SUSAN K. HATTAN, *Minority Staff Director*

SUBCOMMITTEE ON LABOR

HOWARD M. METZENBAUM, Ohio, *Chairman*

TOM HARKIN, Iowa
CHRISTOPHER J. DODD, Connecticut
EDWARD M. KENNEDY, Massachusetts
PAUL D. WELLSTONE, Minnesota

ORRIN G. HATCH, Utah
NANCY LANDON KASSEBAUM, Kansas
JAMES M. JEFFORDS, Vermont
STROM THURMOND, South Carolina

MICHELE L. VARNHAGEN, *Chief Counsel and Staff Director*
PATRICIA KNIGHT, *Minority Counsel*

CONTENTS

STATEMENTS

FEBRUARY 3, 1994

	Page
Metzenbaum, Hon. Howard M., a U.S. Senator from the State of Ohio, prepared statement	3
Mikulski, Hon. Barbara A., a U.S. Senator from the State of Maryland, prepared statement	5
Hatch, Hon. Orrin G., a U.S. Senator from the State of Utah, prepared statement	6
Puhl, Penny, Chicago, IL; Karin Smith, Nashoteh, WI; Steven Bosworth, Simi Valley, CA; William Rand, M.D., Pompano Beach, FL; and John P. Tooker, M.D., F.A.C.P., chairman-elect, Board of Governors, American College of Physicians, Portland, ME	7
Prepared statements of:	
Mr. Bosworth	86
Dr. Tooker	22
Nichols, Sara, staff attorney, Public Citizen's Congress Watch, Washington, DC; Gail Shearer, manager, policy analysis, Consumers Union, Washington, DC; Geraldine Dallek, MPH, Center for Health Care Rights, on behalf of the Coalition for Consumer Protection and Quality, Los Angeles, CA; and David Lyons, vice president, National Association of Insurance Commissioners, Commissioner of Insurance, State of Iowa, Des Moines, IA	35
Prepared statements of:	
Ms. Shearer	50
Ms. Dallek	53
Mr. Lyons	65
Group Health Association of America, prepared statement (with attachment)	148
Family Health Plan Cooperative, prepared statement	161
Arizona Health Care Cost Containment System, prepared statement	164
Maricopa Managed Care Systems, prepared statement	165
American Osteopathic Association, Laurence Bouchard, D.O., prepared statement	167

ADDITIONAL MATERIAL

Articles, publications, etc.:	
Submission by Ms. Karin Smith	77
HMO Provider Contract	89
Will Quality Survive in American Health Care? A Physician's Perspective	119
HMO Physicians' Shared Risk Pools Are Dangerous To Patients' Health, by Ronald Bronow, from HealthSpan, Vol. 10, No. 1, January 1993	121
White Paper On Consumer Due Process Protections, November 30, 1993, from the Coalition for Consumer Protection and Quality in Health Care Reform	125
White Paper on Minimum Requirements for Consumer Information, from the Coalition for Consumer Protection and Quality in Health Care Reform	142

WILL PATIENTS AND DOCTORS BE PROTECTED UNDER HEALTH CARE REFORM?

THURSDAY, FEBRUARY 3, 1994

U.S. SENATE,
SUBCOMMITTEE ON LABOR, COMMITTEE ON LABOR AND
HUMAN RESOURCES, WASHINGTON, DC.

The subcommittee met, pursuant to notice, at 9:34 a.m., in room SD–430, Dirksen Senate Office Building, Senator Howard M. Metzenbaum (chairman of the subcommittee) presiding.

Present: Senators Metzenbaum, Simon, and Wellstone.

OPENING STATEMENT OF SENATOR METZENBAUM

Senator METZENBAUM. Today the subcommittee will hear testimony on one of the most hotly debated issues in health care reform—whether the shift toward managed health care will provide high quality health care to the American people.

An incredible transformation is occurring in medicine today. And all of the attention of the media and the public has been directed to the question of what is happening to the doctors and what is happening to the insurance companies? This Senator and a number of other Senators I know are concerned about what is happening to the patients and what is happening to the sole practitioner/doctor—the Marcus Welby's and Richard Kildare's. They are rapidly disappearing. In his or her place, there now are large group practices and corporate conglomerates. To see a doctor, individuals must maneuver through a network of voice mail telephone, identification card numbers, waiting lists, and a world of people called gatekeepers. Welcome to the new world of managed care.

For many health policy experts, managed health care provided through organizations, generally known as health maintenance organizations or HMOs, is the greatest hope of health care reform. In theory, when individuals sign up with a managed care plan, they agree to use the plan's network of doctors and in exchange are promised comprehensive health services for a fixed annual fee. Because doctors are paid a fixed fee, they have an incentive to control costs, as opposed to fee-for-service medicine which financially rewards doctors for each service they perform.

Health policy experts want to believe that managed care can provide better quality health care than fee-for-service medicine. When managed care works, it works well. It historically has emphasized preventive care and by pulling doctors together, managed care can offer patients and doctors access to a broad array of sophisticated medical technology. But managed care's success has largely been with young populations. Managed care has been notoriously weak

in caring for the most vulnerable in our society—the poor, the disabled, the mentally ill, and the elderly. No one has yet found the perfect balance between fee-for-service, which rewards too much care, and managed care, which rewards the provision of too little care.

One need look no further than the stock prices of HMOs to see that Wall Street believes in their cost cutting potential.HMO earnings increased more than 20 percent last year. A company known as U.S. Healthcare increased 33 percent. The United Healthcare increased 43 percent and Oxford Health Plans increased 73 percent at the end of 1993. And now there is the additional problem of the insurance industry's takeover of the managed care market. HMOs originally were started by doctors who wanted to provide a more holistic form of health care. But now the insurance industry is running the show. Large insurers control 45 percent of the managed care market and for-profit corporations own two-thirds of all the HMOs. We might ask, why should large corporations be organizing and running the delivery of health care?

As I have said many times before, I am very skeptical of the role insurance companies play in our health care system. Over the past 20 years, the insurance companies ruined our system by refusing to insure the sick through a variety of practices such as medical underwriting and preexisting condition exclusions. Time and time again the insurance industry has played fast and loose with their policyholders. Blue Cross engaged in innumerable questionable financial transactions affecting policyholders in West Virginia, Maryland, and New York. Metropolitan Life has recently been excoriated for misrepresenting the policies it sold. And Predential has suffered similar embarrassment in the sale of its securities. Now they say trust us one more time. Let us run the managed care system.

Once we decide as a nation that everyone has the right to an adequate level of health care, there is nothing to insure any more. All that the insurance companies are doing is overseeing the doctors and hospitals, rather than our paying them directly. For the insurance companies to make money, they either have to: first, squeeze down the pay of doctors and hospitals; or second, cut their own administrative overhead and profits; or third cut back on the quality of health care provided to patients. I doubt they will want to cut their profits, which leaves either patients or doctors under their knife. Frankly, I see no reason to keep this layer of unnecessary waste, which currently is siphoning off 25 percent of our health care dollars. Let me repeat that, which is currently siphoning off 25 percent of our health care dollars to the insurance industry.

I am deeply concerned that patients and doctors will not be protected under health care reform. Patients must be able to see their doctors when they need to. Doctors must be free to provide necessary medical care without an army of insurance company auditors looking over their shoulders. While I believe the Clinton health plan seeks to achieve many important health care goals, such as universal coverage, comprehensive benefits, and cost containment, I believe the bill must go further to protect consumers. All I have been reading about in recent days is the whole question of what the AMA is concerned about and what the business community is

concerned about. I want to see more emphasis in the Clinton health care plan on the consumer and on the patients. Those are the ones that I think we need to concern ourselves about. They do not have the high paid lobbyists who are running the halls of Congress these days, working to protect their own selfish interest.

I look forward to hearing the testimony of today's witnesses and working with each of you to ensure that health care reform is fair to both patients and doctors. I am particularly pleased to see my good friend, Senator Simon here with us this morning.

[The prepared statement of Senator Metzenbaum follows:]

PREPARED STATEMENT OF SENATOR METZENBAUM

Today the subcommittee will hear testimony on one of the most hotly debated issues in health care reform—whether the shift toward managed health care will provide high quality health care to the American people.

An incredible transformation is occurring in American medicine today. The solo practitioner doctor—the Marcus Welby's and Richard Kildare's—is rapidly disappearing. In its place, there now are large group practices and corporate conglomerates. To see a doctor, individuals must maneuver through a network of voice mail telephones, identification card numbers, waiting lists and a world of people called gatekeepers. Welcome to the new world of managed care.

For many health policy experts, managed health care provided through organizations, generally known as health maintenance organizations or HMOs, is the great hope of health care reform. In theory, when individuals sign up with a managed care plan, they agree to use the plan's network of doctors and in exchange are promised comprehensive health services for a fixed fee, they have an incentive to control costs, as opposed to fee for service medicine which financially rewards doctors for each service they perform.

Health policy experts want to believe that managed care can provide better quality health care than fee for service medicine. When managed care works, it works well. It historically has emphasized preventive care and by pooling doctors together, managed care can offer patients and doctors access to a broad array of sophisticated medical technology. But, managed care's success has largely been with young healthy populations. Managed care has been notoriously weak in caring for the most vulnerable in our society—the poor, the disabled, the mentally ill, and the elderly. No one has yet found the perfect balance between fee for service, which rewards too much care, and managed care, which rewards the provision of too little care. One need look no further than the stock prices of HMOs to see that Wall Street believes in their cost cutting potential. HMO earnings increased more than 20 percent last year. U.S. Healthcare increased 33 percent, United Healthcare increased 43 percent and Oxford Health Plans increased 73 percent at the end of 1993.

And now there is the additional problem of the insurance industry's takeover of the managed care market. HMOs originally were started by doctors who wanted to provide a more holistic form of health care. But now, the insurance industry is running the show. Large insurers control 45 percent of the managed care market and

for-profit corporations own 2/3 of all HMOs. Why should large corporations be organizing and running the delivery of health care?

As I have said many times before, I am very skeptical of the role insurance companies play in our health care system. Over the past 20 years, the insurance companies ruined our system by refusing to insure the sick through a variety of practices such as medical underwriting and pre-existing condition exclusions. Time and time again the insurance industry has played fast and loose with their policyholders. Blue Cross engaged in innumerable questionable financial transactions affecting policyholders in West Virginia, Maryland, and New York. Metropolitan Life has recently been excoriated for misrepresenting the policies it sold to thousands of nurses. And now they say trust us one more time, let us run the managed care system.

Once we decide as a nation that everyone has the right to an adequate level of health care, there is nothing to insure any more. All that the insurance companies are doing is overseeing the doctors and hospitals rather than our paying them directly. For the insurance companies to make money they either have to 1) squeeze down the pay of doctors and hospitals, 2) cut their own administrative overhead and profits, or 3) cut back on the quality of health care provided to patients. I doubt they will want to cut their profits, which leaves either patients or doctors under their knife. Frankly, I see no reason to keep this layer of unnecessary waste which currently is siphoning off 25 percent of our health care dollars—let me repeat that—25 percent of our health care dollars.

I am deeply concerned that patients and doctors will not be protected under health care reform. Patients must be able to see their doctors when they need to. Doctors must be free to provide necessary medical care without an army of insurance company auditors looking over their shoulders. While I believe the Clinton health plan seeks to achieve many important health care goals such as universal coverage, comprehensive benefits and cost containment, I believe the bill must go further to protect consumers. I look forward to hearing the testimony of today's witnesses and working with each of you to ensure that health care reform is fair to both patients and doctors.

Senator Simon.

Opening Statement of Senator Simon

Senator SIMON. I thank you, Senator Metzenbaum, and I thank you for holding the hearing. As you know, we have a markup in the Judiciary Committee right now, so I am just dropping by and then I have to go what some people regard as a controversial judicial nomination. I simply want to commend you. We have to look at adequate protection for our people and let me just say, I hope the President will not back off on universal coverage. There is growing momentum, I see in this morning's paper, for a plan that does not guarantee all Americans health coverage. That has to be an absolute minimum. I also am concerned when I see talk about backing off of standby price controls. I think if we are going to have a successful health plan that covers people, because there will be increased demand when you have universal coverage, there has to

be a message to health care deliverers that there have to be limits on what they can provide, and we want adequate coverage.

My staff has told me about your situation specifically, Penny Puhl, and I wish I could be here for your testimony. I have read a summary of your situation. But I commend you, Senator Metzenbaum, and I apologize to the witnesses for not being here. My staff will be here and I will get a report on what is being said and I want to work with you to make sure we cover people adequately, and that is the bottom line in all of this.

Senator METZENBAUM. Thank you very much, Senator Simon. I understand you need to go to the Judiciary Committee. I think my proxy is there to vote the same way you will.

Senator SIMON. I have an idea we will vote the same way.

Senator MTEZENBAUM. We will now receive statements for the record by Senators Mikulski and Hatch.

[The prepared statements of Senatord Mikulski and Hatch follow:]

PREPARED STATEMENT OF SENATOR MIKULSKI

I want to thank the chair for holding this hearing. This is a very important issue which must be discussed. From my earliest days in the House, I have been concerned that consumer protection be included in any legislation—especially legislation in the area of health care.

I believe that people:

—have the right to know

—have the right to be heard

—and have a right to be protected from forces over which they have no control.

Nowhere is that more true than in health care. I have tried to incorporate these values into my health care initiatives in the Senate. My women's health framework was designed to make sure that women had access to services. The Office of Women's Research at NIH addresses specific consumer needs in the area of women's health.

I believe we must maintain the consumer focus as we consider health insurance reform. Choice, access, affordability are important safeguards for consumers. I also believe in reducing the hassle-factor and "good guy bonuses" for those people who play by the rules.

Better informed citizens are better decision-makers. I have some concerns about HMOs. I believe that maintaining choice and allowing consumers to choose their own providers helps build relationships between doctor and patient. Decisions about health care promotion and treatment should be done as a partnership in doctors offices and not across the country in a corporate headquarters.

I know that President Clinton has attempted to build consumer protections into the legislation. He has focused on quality and prevention. Choice and access. We need to insure that these provisions are maintained in the final legislation and for some parts of the bill we need to strengthen. The anti-discrimination language could be stronger. Quality assurance provisions need to be clarified. The programs that are established should not be just another bureaucracy but have a real mission to insure quality care.

I look forward to hearing the testimony of both our consumers and providers. This is an important hearing. We will be reminded of what we are trying to do and for whom.

Thank you, Mr. Chairman.

PREPARED STATEMENT OF SENATOR HATCH

Mr. Chairman, first of all, let me thank you for scheduling this hearing today to address the interests of patients and doctors alike in the context of health care reform legislation.

I must say for several months now we have had the so-called "experts" before this committee as well as many other committees and subcommittees in Congress, to testify on the complex issues associated with the various health care reform bills.

As my colleagues well know, these briefings and hearings can get very technical. We have been focusing on the impact on existing Federal and State programs. We have been focusing on the impact on costs, duplication, bureaucracies, and countless other implications.

This is why today's hearing is particularly important and meaningful, because we will focus on the impact on people, and what reform may mena for all Americans.

I will tell you candidly that I have many concerns regarding "managed competition" particularly in the context of a federally mandaed program where individuals and physicians loose control over determining what is best for patient care. I simply do not think "managed competition" is the panacea for curing all that ails health care in America.

As I am sure our witnesses can appreciate, Members of the Senate and House have considerable work ahead in developing any form of health care legislation. As you also know, President Clinton wants to enact legislation this year. We have a lot ow work to do, and considering the implications for all Americans on what we do, there is really not much time remaining. But, there is no percentage in doing it "fast," but not doing it right. In the care of our entire health care system, we must get it right.

In the months ahead we will hear from nuymerous citizens representing almost every sector of American society. During this process, it will be absolutely essential that we not loose sight of the most important and fundamental issue associated with health care reform, and that is—what will be the ultimate impact on patients and physicians?

We are fortunate to have you here today. We will learn from your experiences, and I certainly hope that your experiences will serve to guide us as we address health care reform.

Senator METZENBAUM. Thank you. I am happy to welcome the witnesses this morning.

Penny Puhl, we are happy to have you here with us.

STATEMENTS OF PENNY PUHL, CHICAGO, IL; KARIN SMITH, NASHOTEH, WI; STEVEN BOSWORTH, SIMI VALLEY, CA; WILLIAM RAND, M.D., POMPANO BEACH, FL; AND JOHN P. TOOKER, M.D., F.A.C.P., CHAIRMAN-ELECT, BOARD OF GOVERNORS, AMERICAN COLLEGE OF PHYSICIANS, PORTLAND, ME

Ms. PUHL. Good morning, thank you, Chairman Metzenbaum, for inviting me to speak to you today. My name is Penny Puhl, and I live in Chicago, IL. I am here to tell you about my experiences with a managed competition health care system, and how I almost died as a result of its efforts to control costs by refusing care.

Today I am alive and reasonably healthy as a result of a liver transplant in October 1993. I am now uninsurable for the rest of my life, unless I remain on Medicare and/or Medicaid. I am deeply grateful to the medicare Program, for which I qualified because of my long-term disability, for finally making it possible for me to receive the care I needed. However, at many points during the last 7 years I almost died from end-stage liver disease. I am alive today because I fought aggressively for the health care I needed, not because the system made it readily available.

In 1989, upon the advice of my physician, I left Chicago and moved to Arizona to live with my mother because I was too sick to care for myself. In Arizona, I applied for medicaid. The Arizona variation of the medicaid program is called AHCCCS, the Arizona Health Care Cost Containment System. It is available to persons with maximum incomes of $3,200 per year, or $266/month after out-of-pocket medical expenses. This program, commonly known as "Access", almost let me die. An eligibility worker there actually told me that they were trained to find reasons to deny coverage to applicants. Even with such rigorous eligibility procedures, program costs have risen astronomically. I believe it is administratively very expensive to keep hospital beds empty and contracting doctors' waiting rooms clear of Medicaid recipients.

I arrived in Arizona after a 3-week hospitalization for a major abdominal hemorrhage resulting from end-state liver disease. After many bureaucratic delays, I was approved for Medicaid, and the computer assigned me to the Maricopa County Health Plan and to the County Hospital and the El Mirage health Clinic for my care. I could use no other facilities. At the clinic, I was refused permission to see the part-time physician, and was instead seen by a physician's assistant. He never examined me, and told me to take a Tylenol and get rest. This wildly wrong advice (Tylenol is poisonous to a person in my condition) was the extent of the medical care I received at the clinic. I demanded my case be transferred to Maricopa County Hospital, where I was at least able to resume taking the medications prescribed by Mayo Clinic and my Chicago internist.

During one of my hemorrhages, I went to the emergency room of the County Hospital and was refused admission. I couldn't believe it! I begged the physician to study my white and red blood cell counts to verify that I was hemorrhaging, but she told me they were always low and told me I was being discharged. I fainted twice while waiting for a ride. I knew I was hemorrhaging and pleaded to be admitted, But I was given a glucose I.V. and dis-

charged again. When the hospital driver finally took me home, I lost consciousness on the driveway. Fire Department paramedics worked on me for forty minutes before they deemed it safe to move me to the local private hospital, where I remained for three weeks.

On another occasion, I requested medical treatment to remove a large number of lesions on my face, which bled spontaneously and copiously as a result of my liver disease. In spite of extensive medical documentation of this problem, I was refused care. I was advised to go to the local emergency room during three of the bleeding episodes in order to have the condition re-documented, and I was refused care again. Finally, after many protracted efforts spanning a year and a half, I was allowed to see a plastic surgeon for the condition.

Let me say a word about state-by-state variations. Arizona's Medicaid does not fund liver transplants for adults; the only transplant center in the State does not do enough liver transplants to be Medicare-approved. In order to qualify for a liver transplant I was told that I would have to be near death, and relocate to a state in which there was a Medicare-approved facility. As a result, the system not only allowed, but insisted, that I have eight major abdominal hemorrhages in order to be put on the transplant list. I could have easily died during any one of the episodes. And the many hospitalizations were not cheap.

I know that the Arizona managed care system known as AHCCa (Access) was specifically set up to keep health care costs down in the State medicaid program by denying access to care. I know it because I lived it. I think it is not only brutal and cruel, but criminally inhuman to allow people to go through what I went through. Essentially, I waited five years for appropriate treatment because chronic illness made me indigent. I am very grateful to the State of Illinois that I was given a liver transplant with the assistance of the Medicaid and Medicare programs there. I cannot tell you how much ingenuity, determination, perseverance, and suffering it took.

Cost containment in a multi-tiered system will always mean inferior care for low-income people. Always. Assignment to a health plan which does not offer competent specialists in the field of your medical needs—even for a year—can hasten your death, especially if you are disabled by life-threatening illness. I urge you to create a universal access program which is also a universal benefits program. Only a single-payer approach, encompassed in Senator Wellstone's legislation, S. 491, would accomplish this.

President Clinton's plan, while it promises universal access, cannot truly achieve this by creating its elaborate multi-tiered system. I spent four horrid years in the bottom tier. I felt my treatment, or rather lack of it, was designed to hasten my death. Then I spent 3 years in the considerably better medicare tier. Unless all members of the society are given access to the same care in the same system, life-threatening efforts to contain costs by limiting critically needed care will continue to be foisted on those least able to defend themselves—and will result in death to the chronically ill, countless emergency room treatments, and huge expenses for withholding appropriate treatment in favor of short-term, band-aid solutions and short-term cost savings.

Also, the Clinton plan would make it impossible for patients to choose their doctors. for people with chronic illness and disability, it is critical that we have access to any physician in the United States who has the skills we need.

What happened to me could happen to anyone. You never know when you will be struck with a life-threatening illness. whether it is cancer or heart disease or, as in my case, liver disease. You never know when you will become medically indigent. I never thought I would. Each of us should have the security of knowing we will get the care we need, that we can see our own physicians, not just the ones chosen by our insurance company. That can only happen in a single, unified system.

It is only by the grace of God that I sit here today. Please spare others the experience I had. Create a single-payer health care system for you, for me, our families, and the rest of the country.

Senator METZENBAUM. Our next witness is Karin Smith?

Ms. SMITH. Good morning. My name is Karin Smith and I am grateful for the opportunity to speak before this subcommittee on an issue that is crucial to all of us. Today I want to share with you my personal story on how HMO has cost me my life. I am a member of a staff model HMO called Family Health Plan. It is headquartered in Milwaukee, WI, and has 105,000 members.

I am 28 years old and have advanced cervical cancer, which is a direct result of 3 year misdiagnosis by my HMO. For 3 years, which consisted of 15 office visits and 10 phone calls, I complained about gynecologic problems I was experiencing. And even though my medical records were documented with the classic physical characteristics and symptoms of cervical cancer, no doctor at my HMO ever made the correct diagnosis. Because of my continued complaints, the HMO did perform three biopsies and three pap smears, all of which indicated cancer, but all but one were misinterpreted as benign by the lab my HMO had contracted with.

During these 3 years, my symptoms progressed rapidly. Minor bleeding became profuse, accompanied by fatigue and passing out. I was frustrated by the medical care I was receiving and I was scared by what appeared to be an obviously deterioration in my condition. Yet the doctors at my HMO kept telling me that basically I was okay. I knew better. My only alternative was to see a gynecologist outside of the plan who immediately suspected I had cervical cancer. His suspicions were confirmed by a surgeon shortly after our initial visit.

Had my cancer been diagnosed at the time my first pap smear was misread by my HMO, I would have had a 95 percent chance of survival. However, due to their gross incompetence and shameful errors, I am now dying. I am only 28 years old and am told by my doctors that I will probably not live to see my 30th birthday. My cancer has spread through my lymphatic system from my pelvis to my abdomen, and as of 2 weeks ago, to my neck. The fifth vertebrae of my upper spine is so completely infiltrated with cancer that at any moment I may become paralyzed.

Since my diagnosis, two-and-a-half years ago, my life has been consumed by one horrifying medical procedure after another. I have endured three separate courses of radiation, 6 months of inpatient chemotherapy, and seven surgeries. At times I have laid in

the hospital bed isolated from my family, friends, and even my husband because my immune system was so suppressed that a minor cold could destroy me or my frail body was riddled with infection or radioactive materials were implanted into my internal organs and I withered in pain.

I have spent countless days and nights nauseated and sick from both radiation and the chemotherapy. The chemotherapy alone caused me to vomit almost every day for the 6 months I was in treatment. Every third week I would be admitted into the hospital for 6 days, where drugs that made me terribly sick would flow through my body. I was bald for nearly a year and all of my activities were severely restricted because my immune system was so suppressed.

I am scheduled to be in radiation to the left part of my neck and under my left arm. One can only imagine and fear what the side effects of this treatment will be. As my last hope, I am currently awaiting news from my doctor to find out about whether or not I am a candidate for a bone marrow transplant. Although the physical treatment has left me with disfiguring scars from my pelvis to my neck, the emotional scars cut much deeper. I am so young, yet my career as a CPA is over. I am married to a wonderful man, but I will never bear his children. My parents will outlive their youngest child.

This has not only affected me. It has shattered the lives of everyone around me. And how does one explain this to my husband, my parents, my sisters and brothers, my friends? All of our lives have been forever changed by this unnecessary and senseless tragedy. At this point, my personal medical future is plagued by this nightmare. Now I feel I must focus my concerns on the medical future of our country. If we allow HMOs to be the foundation of the proposed medical system, we are encouraging the most important profession of our country to put the financial needs of their bottom line before the medical needs of their patients.

It was no coincidence that the lab which was contracted by my HMO performed inferior work. The owner was on the HMO's board of directors, and in order to retain the HMO's business, he was forced to meet or beat lab prices from the competition. I think that is what President Clinton now calls managed competition. All of their contracts are negotiated this way. It is a system that encourages the lab to provide services at artificially low prices which leads to lack of quality control measures and excessive workloads.

To add insult to injury, the technician who misread all of my pap smears was reading five times the recommended number of slides. She also worked at as many as four other labs in the Milwaukee area at the same time. And when she was fired from my HMO for falsifying records in 1991, the HMO hired her directly to supervise their new in-house gynecologic laboratory. In addition to myself, several other women in the Milwaukee area have been forced to suffer this plight because of my HMO's gross failure to provide safe and competent medical care. One woman died last year. She was only 40. Her pap smear was misread just like mine. Another woman, whose tests were also misread, is just waiting to die.

We cannot change my future, but I can give you a look into your own. I am an example of the health care in this country, as pro-

posed by the Clinton administration and it horrifies me. I have experienced firsthand the amazing lack of continuity of care, lack of communication, lack of responsibility, lack of accountability, lack of humanity, which are all hallmarks of the managed care plans in this country.

We all know there is a serious health care crises in this country. No one should be denied access to care. We need a realistic, rational health care system that will prevent financially self-interested groups from continuing to prey on unsuspected medical consumers. We need a health care system that allows choice, provides accountability, and incorporates a serious medical malpractice prevention program. As a victim of medical malpractice, I implore you, please do not let this administration strip away the rights of victims like me. Please let my HMO experience be your guide. Understand that managed care is part of our health care problem. It is not the solution.

Senator METZENBAUM. Thank you very much, Ms. Puhl and I say to the other witnesses that I think the medical system short changed Ms. Puhl. I think we are lucky that she is still with us. I did not think the U.S. Senate ought to short change her and give her an opportunity to tell her story, so we let you run over a little bit. But you tell us a very powerful story. I think we will hold our questions until we have heard all of the witnesses. But on behalf of Senator Wellstone and myself, because I am a cosponsor of this bill, we appreciate your endorsement of the single payer bill.

Ms. PUHL.I am very happy to be here and to be able to be here.

Senator METZENBAUM. Thank you very much.

Our next witness is Karin Smith.

Ms. SMITH. My name is karin Smith and I am grateful for the opportunity to speak before this subcommittee on an issue that is so crucial to us all. Today, I want to share with you my personal story of how an HMO has cost me my life.

I am a member of a staff model HMO called Family Health Plan, It's headquartered in Milwaukee, WI and has 105,000 members.

I am 28 years old and have advanced cervical cancer, which is the direct result of a 3 year middiagnosis by my HMO. For 3 years, which consisted of 15 office visits and 10 phone calls, I camplained about gynecological problems I was experiencing. And even though my medical records were documented with the classic physical characteristics and symptoms of cervical cancer, no doctor at my HMO ever made the correct diagnosis.

Becuase of my continual complaints, the HMO did perform three biopsies and three pap smears. All of which indicated cancer. Yet, all but one were misinterpreted as benign by the lab my HMO had contracted with.

During those three years, my symptons progressed rapidly. Minor bleeding became profuse, accompanied by fatigue and passing out. I was frustrated by the medical care I was receiving and I was scared by what appeared to be an obvious deterioration in my condition. Although the doctors at my HMO kept telling me I was basically OK, I knew better. My only alternative was to see a gynecologist outside of the plan, who immediately suspected I had cervical cancer. His suspicions were confirmed by a surgeon shortly after our initial visit.

Had my cancer been diagnosed at the time the first pap smear was misread by my HMO, I would have had a 95 percent chance of survival. However, due to their gross incomptence and shameful errors, I am now dying. I am only 28 years old and am told by my doctors that I will probably not live to see my 30th birthday. My cancer has spread, through my lymphatic system, from my pelvis to my abdomen and as of 2 weeks ago, to my neck. The fifth vertebrae of my upper spine is so completely infiltrated with cancer that at any moment I may become paralyzed.

Since my diagnosis two and a half years ago, my life has been consumed by one horrifying medical procedure after another. I have endured three separate courses of radiation, 6 months of inpatient chemotherapy and seven surgeries. At times I have laid in a hospital bed, isolated from my family, friends, even my husband, because my immune system was so suppressed that a minor cold could destroy me, or my frail body was riddled with infection or radioactive materials were implanted into my internal organs and I writhed in pain.

I have spent countless days and nights nauseated and sick from both the radiation and the chemotherapy. The chemotherapy alone, cuased me to vomit almost every day for the six months I was in treatment. Every third week I would be admitted into the hospital for 6 days where drugs that made me so terribly sick would flow through my body. I was bald for nearly a year and all of my activities were severely restricted.

Next week, I am scheduled to begin radiation to the left part of my neck and under my left arm. One can only imagine, in fear, what the side effects to this treatment will be. And as my last hope, I am currently awaiting news from my doctors to find out whether or not I am a candidate for a bone marrow transplant.

Although the physical treatment has left me with disfiguring scars from my pelvis to my neck, the emotional scars cut much deeper. i'm so young, yet my career as a CPA is over. I'm married to a wonderful man but I'll never bear his children. My parents will outlive their youngest child. This hasn't only affected me. This has shattered the lives of everyone around me. How does one expalin this to my husband, my parents, my sister and borhter, my friends. All of our lives have been forever changed by this unnecessary and senseless tragedy.

At this point, my personal medical future is plagued by this nightmare. Now, I feel I must focus my concern on the medical future of our country. If we allow HMO's to be the foundation of the proposed medical system, we are encouraging one of the most important professions of our country, to put the financial interests of their bottom line before the medical needs of their patients.

It was no coincidence that the lab which was contracted by my HMO performed inferior work, the owner was on the HOM's board of directors and in order to retain the HMO's business, he was forced to "meet or beat" lab prices from the competition. I think that's what President Clinton now calls "managed competition." All of the contracts will be negotiated this way. It's a system that encourages the lab to provide services at artificially low prices, which leads to lack of quality control and excessive work loads.

To add insult to injury, the technician who misread all of my pap smears was reading 5 times the federally recommended number of slides. She also worked at, as many as, four other labs in Miulwaukee at the same time. And when she was fired from my HMO's contracrted lab for falsifying records in 1991, the HMO hired her directly to supervise their new in house gynecological laboratory.

In addition to myself,f several other women in the Milwaukee area have been forced to suffer this plight because of the HMO's gross failure to provide safe and competent medical care. One woman died last year, she was only 40—her pap smear was misread just like mine. Another woman, who's test were also misread is just waiting to die.

We can't change my future. But I can give you a look into your own. I am an example of what health care in this country will become as proposed by the Clinton administration and it horrifies me. I have experienced, first hand, the overwhelming lack of continuity of care, lack of communication, lack of responsibility, lack of accountability and lack of humanity which are the hallmarks of managed care plans in this country today.

We all know that there is a serious health care crisis in this country—no one should be denied access to care. We need a realistic, rational health care system that will prevent financially self interested groups from continuing to prey on unsuspecting medical consumers. We need a health care system that allows choice, provides accountability and incorporates a serious medical malpractice prevention program. As a victim of malpractice, I implore you—please do not let this administration strip away the rights of victims like me. Please let my HMO experience be your guide. Understand that managed care is part of our health care problem. It is not the solution.

The chronology submitted by Ms. Smith appears at the end of the hearing record.

Senator METZENBAUM. Thank you very much. I just cannot tell you how gratefull I am to the two of you for having the courage to come here and testify. Your testimony is unbelievably powerful and I think that therte are a lot of other things you might be more inclined to be doing today than be testifying before a Senate committee. But I want you to know that your testimony is extremely helpful and on behalf of all of the members of the committee, and I would like to tell you that just a host of committee hearings are taking place at this very moment in the Senate and that is reason some of our members are not here today. Because I know many of them have a very strong interest and a concern. Thank you. You are very helpful. I will have some questions, but we will go through the panel first.

Mr. Bosworth.

Mr. BOSWORTH. Thank you, Mr. Chairman. My wife and I have practiced in the health insurance field for well over 10 years. She has worked for one of the largest HMOs in the country, HealthNet. She is also intimately familiar with the policies of managed care organizations. I own an independent brokerage firm representing a diverse group of employers, including physicians in the purchase

and management of employee benefit plans, the largest being health insurance. We also happen to be covered by an HMO plan.

So you can see we do have experience and knowledge in the subject of managed care. Unfortunately, our experiences have been quite horrifying and our knowledge of the industry has been greatly increased by our experience.

In 1989, my wife discovered a lump in her breast. She immediately made an appointment to see our then, primary care physician to obtain a referral authorization for a mammogram. He refused, citing her young age which was 29, even though she had a history of fibrocystic breast disease. Not satisfied with his laissez-faire attitude, we returned a month later to insist on the referral. At this point, a new lump had developed under her arm. The doctor informed her that she had "lumpy breasts and a fatty tumor" under her arm. However, at my insistence, he reluctantly said he would try to obtain the okay from our HMO for the mammogram.

In January 1990, after a 5 month wait, the mammogram was approved and performed. When we called for the results, the doctor said there were no problems. At this point, we decided to apply for other health insurance that would allow us more freedom and control over our own lives. We needed to have this doctor put in writing his diagnosis, so that we could obtain the new insurance. He refused to do this until he performed a biopsy. This raised questions on our part to the truth of his diagnosis. We obtained the mammogram report and found that there was quite a different story to be told.

At this point, we went outside of the HMO system at our own expense to obtain a biopsy. Our worst fears were realized when the diagnosis of breast cancer was returned. A week later my 30-year old wife was undergoing surgery to remove the affected breast. After 6 months of aggressive chemotherapy, we thought that this thing was behind us and that we could get on with our lives. However, within a year, we found that the cancer had reoccurred, this time to her liver and to her bones. Our only curative hope was for her to have a bone marrow transplant.

When she spoke to her employer, HealthNet, about the treatment, they assured her that they would cover the treatment if she wanted it. To our utter amazement and dismay, HealthNet instead tried everything in the book to avoid paying for this potentially life-saving treatment. They even tried to manipulate our physicians by getting them to say that nothing could be done, that her case was hopeless, and that she should go home to die. When we did find that there was hope and that the bone marrow transplant would help, our only recourse was to file a lawsuit against HealthNet.

Eventually, HealthNet did pay for the treatment. It was not as expensive as they had all of us to believe. The total cost was under $75,000, a small price to pay for the health of a young, active, productive mother of a 4 year old child.

We continued to be manipulated by HealthNet. They then refuse to allow my wife to be seen by her physician who performed the bone marrow transplant. We were forced, once again, to go outside the system and pay for her checkups out of our own pocket.

Through the course of these events, we have discovered and have proof of a grand scheme of cover-ups, lies, manipulation, coercion,

collusion, and similar scandalous tactics that should be investigated by the highest Government authority.

Physicians and other health care providers who serve HMO patients, tell of similar experiences of manipulation and coercion on the part of HMOs to limit and/or delay necessary medical care. It is quite noteworthy that these organizations collect our premiums for health care and through a maze of financial incentives, they manage to keep over half of the premiums to add to their ever-burgeoning profits.

Where is the value to an HMO subscriber who pays over $150 per month for medical care and yet, his or her physician only receives about $40 to provide all their medical care. Why are these organizations allowed to dictate medical care and allowed to practice medicine without a license. Corporations have no right to interfere with the sacred relationship between the physician and the patient.

My professional and personal experience with managed care is that they claim to contain costs only by denying benefits and services. This point is proven in my wife's case and there is evidence of this in countless case histories. Studies by the Rand Corporation and Congress question the real cost savings of managed care plans. I would add that many times these savings are falsely achieved by shifting costs to indemnity or other type health insurance plans or to individuals who pay cash for their care.

Now I do not assume to be more knowledgeable than anybody, especially you, in your quest for solutions to the health care problem. Through professional and personal experience, I would offer you this advice. No matter what anyone or any organization has told you about managed care, do your own investigation. Do not rely on the data that is produced by managed care groups, for there is counter data available that will dispute all of their claims. Look at everything and ask for proof of every claim. Above all, remember that your decisions will ultimately affect the lives of over 200 million people.

Now at this time, I would like to submit for the record if I might, an actual HMO provider contract that shows how HMOs use financial incentives to manipulate physicians to the detriment of patients.

Senator METZENBAUM. Without objection, it will be included in the record.

[The information referred to appears at the end of the hearing record.]

Mr. BOSWORTH. And I have two articles by a Dr. Ron Brown, explaining in lay terms, the financial workings of HMOs and I would like to submit those also, sir.

Senator METZENBAUM. Very pleased to have them and will include them in the record.

[The information referred to appears at the end of the hearing record.]

Senator METZENBAUM. We thank you for your testimony, Mr. Bosworth and we hope your wife does well.

Mr. BOSWORTH. Thanks.

[The prepared statement of Mr. Bosworth appears at the end of the hearing record]

Senator METZENBAUM. The next witness is well known to me. He is a friend. He also has performed cataract surgery on my eye, so I am making a full disclosure, for which he was paid, as all doctors are paid. But I do feel it appropriate that I make it clear that I know Dr. Rand previously and I am happy also to say that the cataract surgery was very successful. Dr. Rand, with that introduction, you are on your own.

Dr. RAND. My name is Dr. William J. Rand, and I enjoy a reputation as a leading eye surgeon and as an innovator in my field. I am the Director of the Rand Eye Institute, a center of professional excellence and one of the largest eye surgical centers in the country.

I have a different background and perspective than most of the other health care experts you have been hearing Horn, over the years.

I have participated in the development and improvement of some of today's most innovative technology for sight restoring cataract surgery, including small incision sutureless cataract operations, instantaneous vision restoration, and the new intravenous analgesia technique that frees patients from the risk of ocular injections.

I am one of the most experienced eye surgeons in the country, with more than 15,000 major eye operations to my credit. Since the average eye surgeon will perform only 700 to 1,000 operations during an entire career, my experience with patients is verifiably extensive. I am 47 years old, but I have 15 times a lifetime of experience in caring for patients in their hour of need, restoring eyesight, in many cries to those deemed hopeless by others with the same title, but with less experience. My patients come not only from Florida, but from all over the country and from many other countries around the world. Many patients have sought my services, gladly bearing all of the costs of travel and medical care, even though they could have received so called "identical care" offered totally free of charge by their own country's universal health care system.

I have conceived, developed and directed the and Eye Institute, and the Rand Eye Foundation, the federally certified non profit clinical research and education division of the Rand Eye Institute. I have been a teacher to many doctors who have traveled to the Rand Eye Institute from distant states and from foreign countries. I have provided advanced technology and post graduate surgical instruction to thousands of eye surgeons through videotaped instruction presentations, national and international lectures, and Eye Institute supported clinical research fellowships and during ten consecutive years as course director for the highly regarded Southeast Regional Cataract Microsurgery course, always without personal gain.

Being in contact with so many colleagues from other countries, I often hear their lamentations about the lack of available equipment and technology, long waiting lists for hospitalization and procedures. Sight restoring and even life saving procedures delayed or denied. Persons sentenced to death or disability in the name of cost containment and limited financial resources. One thing I have learned that characterizes all these alien health care systems. Since older people are not as productive, they are inevitably the

first to be subjected to the withholding of care, determined by someone who is not even a physician.

I serve without salary, as one of the directors of the Diabetes Research Institute Foundation, at the University of Miami School of Medicine. I am a substantial financial contributor and actively raise funds for the Diabetes Research Institute's intensive research program that we expect will actually cure and eradicate diabetes before the end of this century.

Because of our religious beliefs, my wife and I have been committed to donating 20 percent of our net income to various charitable causes.

I am the father of a diabetic son, now 9 years old, who has required at least four insulin injections every day to keep him alive, since he was 14 months old.

My father, God bless him, will be 84 years old next month. For ten years, he has suffered from AIzheimers disease, with progressive mental deterioration. We have been taking care of him in our home for three years, with around the clock caregivers, at great expense.

I have learned how it feels, to be the head of a household with massive non covered healthcare expenditures. I know what it is like to worry about a brilliant and beautiful diabetic son who would not be alive without the ongoing care he receives from our medical system. I know first hand what it means to be dependant upon future medical technology innovation.

I believe that all this has given me a unique perspective on health care issues, and uniquely qualifies mo to render opinions with an expertise that few can match. Senator Metzenbaum knows me and the Rand Eye Institute, and what a dedication to excellence is all about.

In Washington, if you can throw around statistics you look like an expert. I'm a just a doctor. I'm not going to give you statistics. I'm here to try to give you common sense, tempered by my expertise, because I am intimately involved in every aspect of the health care system. As I said I am 100 percent committed to excellence in my field.

Senator Metzenbaum, the reason I accepted your invitation to appear before this prestigious panel, is because I want to tell you that our nation's noble effort to provide universal access to our health care system is going astray. I believe that we share a common goal. We all want to assure that each American has access to the high technology medical system that so many of our citizens enjoy.

Those of us that are among America's most outstanding clinicians, have not been heard from. We are the segment of the medical profession that the public seeks out when they simply must have the best. We are the great innovators and we provide our patients with an additional level of care.

I am sorry Senators, there is no provision for excellence in the current health care reform proposals.

The impending enactment of managed competition legislation, has created compelling incentives for venture capitalists, insurance companies, physicians and hospitals to form managed care relationships that are a perversion of the legislative intent. It is acquiring

a life of it's own. It is becoming a breeding ground for mediocrity and the instrument of the physical and mental abuse of it's captive audience, patients and doctors alike.

In the world of managed care, skilled public relations specialists, contrive terminology and linguistic euphemisms to create the illusion that the new world of managed competition is even better than the great American health care system that exists today. Terms such as excellence in health care, quality care, competitive pricing, full service, choosing a doctor of your own choice, primary care physician and friendly gatekeeper, are merely the public relations jargon of a system in which only profits matter.

Managed care has become a patient distribution system, brokered by middlemen. Corporations are skimming off 30 or 40 percent of the patient care dollar right before your eyes.

Managed care has become a euphemism for "brokered" care. A new middleman layer of health care brokers is being developed. Ostensibly, these HMO's or managed care plans are paid for their expertise in managing the health care efficiency and assuring quality care for a group of assigned patients. But in reality these brokers do nothing more than administer the distribution of contracted blocks of patients to the same local doctors and hospitals, where they were cared for before. They either contract with doctors for reduced fee, ridiculously reduced fee, or payment by capitation arrangements.

These "robber barons" extort 30 or 40 percent of every health care dollar, every day, every year now and forever. All this for having originally matched and continuing to allow the doctors to see their patients. No matter what they say about quality control, all they do is broker care. Where 100 percent of the patient care dollar once went to pay for the time and labor inherent in quality patient care, now only 60 or 70 percent can reach the provider. Next year it will probably be 50 percent, and who knows what will follow. The difference is redistributed profit, not a saving to the health care system.

TPA's or third party administrators, are an additional middleman layer. They actually subcontract with the large health plans for rights to a certain number of the plan's patients and make deals with the doctors in the TPA's local area. They broker the broker's patients, back to the same doctors who used to take care of the same patients before their care began to be managed. The health plan gives up 10 percent to the TPA's and keeps the remaining 20 or 30 percent, no longer having to go out and even recruit patients.

Some TPAs function as insurance agents, arranging contracts, and collecting a one time fee. Most TPAs, however, function as if they were their own managed care plan and continue to receive 10 percent of the ongoing health expenditures, forever. There are some people making millions of dollars a year being a TPA.

In order to maximize profits, the managed care entity seeks out the lowest bidder, ignoring quality and humanity. They must actively engage in the withholding of services. Any unnecessary corporate expense is a loss of money. Any service that can be denied or withheld is good financial policy for the corporation.

In many managed care organizations, a doctor, euphemistically known as the gatekeeper, a general practitioner with no specialty training is given the ultimate power of triage. How could anyone without advanced training make reliably accurate decisions as to who needs a specialist and who does not. The gatekeeper is not a friendly doorman at the gates He is not Marcus Welby. Gatekeepers are guards placed there to keep you and your family out of the hands of the more skilled professionals and specialists. For managed care to be maximally profitable, it requires restricted access.

With the newfound power of the managed health plans, an almost free hand can be, and has been used in setting rates and terms with doctors. But it gets worse. These powerful health care organizations are now routinely signing up doctors for capitation agreements on most new contracts.

Capitation is when doctors are paid by the head, per capita, in advance, a certain fixed dollar amount for each member of the group of patients bound to him, multiplied by the total number of patients in that group.

On the surface, capitation makes sense. It is the one sure way to drive down health care expenses. But it does so at a terrible cost in pain and suffering for the patient, because it provides every incentive for abuse of the patient. It fosters a disincentive-to-care system. The doctor makes the same income from those patients, whether or not he sees the patients, treats them or not, or whether he does surgery on them or not. The doctor earns more if he spends his time on other income producing patients and he loses time and money every time he provides a service to a capitated patient. These capitation arrangements pay the doctor from 30 percent to 60 percent of what the normal reimbursement for time, expenses and labor would be. The insurance company or managed care organization keeps the rest as corporate profit, or profiteering.

Capitation payments to managed care providers should be illegal. Every incentive is in the reverse direction. The patient is often put in the position of begging his doctor for care and tests and treatment. I have seen many abused patients who were denied medical and surgical care. I have seen patients who have been told that at 65 years old, they were too old for "dangerous" cataract surgery. Or that one seeing eye was enough. I have seen eyes lost because of low technology surgery, or because of pathology that was discovered too late or not at all because the doctor gave only a two minute eye exam. You get what you pay for. Care of a patient must not be allowed to be a total loss or an expense to the caregiver. He will find every reason to spend less on care and you will get patch jobs whenever he can get away with it.

By our failure to regulate this emerging industry, we essentially set managed care loose on our population. Now the players in this system are so strong and powerful that it will be almost impossible to stop them. It is so lucrative that everyone is buying up everybody they can. Insurance companies are buying up the venture capitalists. The bigger insurance companies are buying up the smaller ones. Bigger and bigger companies are buying up hospitals and managed care health care networks. I am amazed how many people want to buy the Rand Eye Institute. But it is not for sale, yet. Only

by abolishing capitation agreements, by law, would things ever have a chance of turning around.

On the surface, the patient does not see that he has been bought and sold. The patient is given a rosy picture of linguistic euphemisms to replace the quality in his or her care. The patient is shielded from out of pocket charges by corporate or government edict. This looks great to the healthy patient who does not have to consume health care services. But it has the effect of denying each patient the benefit of adequate funding of his health care. In short, the government thinks it has fixed everything. The corporation gets something for nothing. The patients have the illusion that they are getting something for nothing. The doctors quickly learn how to provide less, for the little something they get. It is only when the patient is enfeebled by the need to consume health care services, that denied access and limitation of care come into play. When in the course of human history can you get something for nothing.

Senator METZENBAUM. Thank you. Your testimony was very interesting. We are very pleased to have it, and indeed, youdud gi iver a bit, but I guess the world will not come to an end.

We will now hear from Dr. John Tooker, who is speaking on behalf of the American College of Physicians. Dr. Tooker, we are happy to have you with us, sir.

Dr. TOOKER. Thank you, Mr. Chairman. Good morning. My name is Dr. John Tooker and I practice internal medicine in Portland, ME, and I am testifying on behalf of the American College of Physicians. The ACP is the Nation's largest medical specialty society, with more than 80,000 members who practice internal medicine and its sub-specialties.

Mr. Chairman, the ACP believes that our Nation's health system does not work, as evidenced by the moving testimony of our witnesses today, for either patients or their physicians. One of the principal failings of our current health system is that patients and physicians have increasingly lost control over treatment decisions.

Insurance companies have acquired enormous power which is evidenced by the testimony today. Through their rules and procedures, they often make decisions about a patient's medical treatment over the objections of either the patient or physician. What is particularly appalling is the process of utilization review, criteria by which decisions are made that are often kept secret from both doctors and from patients, are not scientifically based, and often focus exclusively on cost, ignoring issues of quality.

In addition to the faulty criteria used, another compelling problem with these reviews is that they are performed on a case-by-case basis, micromanagement. This intrudes on the doctor-patient relationship and wastes remarkable time and money, since the physician may be forced to justify his or her decisions and most importantly, impairs the quality of care given to the patient.

Let me give you a real life example of how this works on a daily basis. A 15-year old girl in rural Maine was diagnosed with depression and a behavioral disorder that included self abuse. She struck herself in the mouth repeatedly with a hammer. Her internist attempted to obtain expert care for her. He spoke with the pediatrician, specializing in adolescent medicine, particularly with children in crises. The pediatrician was willing to see the patient on short

notice. The insurer, however, who had no understanding of the patient's particular problem and the need for immediate help, balked at the patient seeing anyone other than a psychiatrist, even though in this rural area, there was no psychiatrist available.

The internist was concerned about the patient's safety. He spent an entire afternoon on the phone, making over a dozen phone calls to the insurer to obtain authorization for a single visit to the pediatrician. He finally and dramatically received authorization by asking the insurance company representative and I quote, "What do you want to do, let her kill herself before you will authorize this treatment?"

Mr. Chairman, like my colleague, I became a physician to take care of patients, not insurance companies. Unfortunately, these practices are becoming more and more common. And, therefore, the ACP will insist that health care reform legislation contain provisions to ensure that all physicians, all Americans receive the highest quality of care and that patients and their physicians, not insurers, make decisions about medical treatment.

In addition, we should recognize that while we need to eliminate these practices in the private sector, the Government also micromanages patient care. We cannot substitute through legislation excessive Government regulations for private sector abuses. Unfortunately, the legislative language in the Health Security Act seems to assume that quality can only be assured by creating a new and very large massive bureaucracy to oversee performance and punish health professionals and institutions judged deficient.

Mr. Chairman, we need a new approach. The challenge in health reform is to develop a quality assurance system that creates an environment that fosters collaboration among physicians, their patients, hospitals, and health plans to improve quality, while simultaneously providing for reasonable external review, and when necessary, disciplinary proceedings to protect the consumer.

Health reform legislation must establish a system of ongoing quality improvement that eliminates case-by-case punitive review and instead uses data from practice profiles, processes and outcome to measure quality where possible. It must also integrate considerations of both quality and cost into the delivery of care.

We must research the use and development of consumer report cards to ensure that the consumer has data available that is clinically relevant and appropriate.

Finally, we urge you to adopt a requirement that utilization criteria be disclosed to physicians and to patients; that the criteria be based on reasonable and current medical evidence; and that they be consistently applied. Additionally, physicians should supervise the decisions, including determinations of the medical appropriateness of any denial, as well as the appellant process. Moreover, mechanisms should be established to evaluate the effects of the utilization review program, including provider and patient satisfaction data. We hope to work with you fully to develop recommendations in this area.

In conclusion, Mr. Chairman, we need to create a health system that empowers physicians and their patients. We need to make sure that the quality of care is maintained, micromanagement from external entities, both private and public, is eliminated. We look

forward to working with you to develop legislative solutions to this problem in the upcoming weeks. Thank you for the opportunity to testify on this issue of critical importance to the patient and the physician.

Senator METZENBAUM. Thank you very much, Dr. Tooker.

[The prepared statement of Dr. Tooker follows:]

PREPARED STATEMENT OF JOHN TOOKER, M.D.

Good morning. My name is Dr. John Tooker. I practice internal medicine in Portland, ME and I am testifying on behalf of the American College of Physicians. The ACP is the nation's largest medical specialty society, with more than 80,000 members who practice internal medicine and its subspecialties.

Mr. Chairman, the ACP believes that our nation's health system does not work—for physicians or their patients. One of the principal failings of our current health system, is that physicians and their patients have increasingly lost control over treatment decisions.

Insurance companies have acquired enormous power. They don't just pay claims. Rather, through their rules and procedures, they often make decisions about a patient's medical treatment—even over the objections of that patient and his or her physician. What is particularly appalling is that the so-called "utilization review" criteria by which these decisions are made are often kept secret from doctors and patients, vary by company or payer, are not scientifically based, and often focus exclusively on cost and ignore issues of quality.

In addition to the faulty criteria used, another problem with these reviews is that they are performed on a case-by-case basis. They focus on an individual patient cared for by a particular physician. This intrudes on the doctor-patient relationship, wastes time and money since the physician may be forced to justify his or her decisions, and most importantly, can hurt the quality care provided to the patient.

Since these practices are becoming more and more common, the ACP believes it is critical that health reform legislation address this problem. We agree with the President and the First Lady who have stated that in a newly reformed health system, clinical responsibility should be restored to practitioners and that the current system of "checkers checking checkers" should be eliminated.

The ACP will insist that any final version of health reform legislation contain provisions to ensure that all Americans receive the highest quality care, and that patients and their physicians make decisions about medical treatment—not insurance companies.

In addition, it is important to remember that while we need to eliminate these practices in the private sector, the government also engages in micromanagement of patient care. We cannot substitute excessive government regulation for private sector abuses.

Unfortunately, the legislative language in the Health Security Act seems to assume that quality can only be assured by creating a massive bureaucracy to oversee performance and punish health professionals and institutions judged deficient.

For example, the Act establishes new quality-assurance entities such as Regional Professional Foundations and the National Quality Consortium. As proposed in the Act, however, these entities will simply add to the bureaucracy and therefore should be removed from the legislation. Although the Regional Foundation could serve a data gathering role, all its other proposed duties and the responsibilities of the National Quality Consortium, however, are unnecessary.

Mr. Chairman, we need a new approach. We need to adopt health reform legislation that ends case-by-case reviews, and instead establishes a quality assurance system that uses data from practice profiles—of processes and outcomes—to measure quality. Moreover, health reform legislation should promote development of a system of ongoing quality :provement, that integrates considerations of both quality and cost.

Mr. Chairman, quality in medical care derives primarily from professional and institutional imperatives to achieve excellence. Such excellence comes from within individuals and organizations; it cannot be imposed by an external authority. The challenge in health reform is to develop a quality assurance system that creates an environment that fosters collaboration among physicians, hospitals, and health plans to improve quality, while simultaneously provides for reasonable external review, and when needed, disciplinary proceedings to protect consumers.

The ACP recognizes a role for external oversight and regulation. Licensure, certification, periodic inspections and examinations are important societal mechanisms to assure the public that professionals and institutions have achieved and continue to

maintain an adequate level of competence. In addition, the PROs have authority to sanction physicians for care judged inadequate in quality.

While incompetence or malfeasance should be addressed by formal mechanisms which are apart from medical practice such as licensing and PRO reviews, as well as mechanisms that are a part of medical practice such as credentialing by hospitals, they have little positive effect on the striving for excellence or on continuous quality improvement. Further, an environment choked with threats of discipline and severe sanction will erode the impulse to strive for excellence. Consequently, disciplinary and regulatory activities must be kept separate from the quality improvement environment.

Our recommendations for a new quality assurance system are:

—All health plans should have a quality improvement program and participate in the national effort to develop measures of quality. The legislation should explicitly recognize that the principal responsibility for quality rests on health professionals and institutions.

—There should be no individual case review performed on a routine basis. The task of external oversight should be the profiling of care at the local, state and national levels. The organization which carries out this function should not have any disciplinary or regulatory authority. This will allow practitioners to work in conjunction with individuals who are doing the profiling. Practitioners should come to view these persons as colleagues and not as police.

—Because utilization of services, quality, and cost are interrelated, profiling these different but complementary aspects of care should be the responsibility of one entity. Separation of responsibility can lead to an undue focus on cost with potential compromise in quality. It can also leave considerations of quality unrestrained by the reality of finite resources.

—The profiling function could be located within a new entity or in could be housed at an existing institution and overseen by a representative council made up of practitioner and patient or consumer interests.

—When the profiling indicates a possible lapse in quality, the entity should work with the relevant health plan to investigate the cause of the data variation, and improve the quality performance of the plan.

—When a profile of an individual, an institution, or a community suggests a potential serious problem with quality, that information should be forwarded to appropriate credentialing or licensing authorities. Findings from review of worrisome profiles must be made public in a timely manner by the authority charged with the review.

—In so far as is practical, profiling should be based on reviews from outcomes as well as well developed practice guidelines.

—The licensing of health professionals, hospitals, and health plans should remain the responsibility of state government. The credentialing function should be the responsibility of hospitals and health plans.

—Increased research and development is needed on practice guidelines, profiling, and health plan report cards. The latter would include health plan performance measures and consumer satisfaction surveys. We must ensure that information provided on report cards is clinically relevant and appropriate. The impact of report cards on consumer choice of health plan also requires careful study.

These principles should form the basis of a new quality assurance system. I want to make clear however, that it may be several years before the new quality system is in place. Therefore, it is critical that we provide relief for practitioners and their patients from case-by-case utilization review activities that are occurring now, and may occur during the transition period.

We urge you to adopt a requirement that utilization criteria be disclosed to physicians and patients, that the criteria be based on reasonable, timely medical evidence, and that they be consistently applied. In addition, physicians should supervise the review decisions, including determinations of the medical appropriateness of any denial, as well as an appeals process. Finally, mechanisms should be established to evaluate the effects of the utilization review program—including provider and patient satisfaction data. We would like to work with you to more fully develop recommendations in this area.

CONCLUSION

In conclusion, Mr. Chairman, we need to create a health system that empowers physicians and their patients. We need to make sure that quality of care is maintained, and micromanagement from external entities—private and public—is eliminated. We look forward to working with you to develop legislative solutions to this problem in the upcoming weeks.

Thank you for the opportunity to testiH on this issue of critical importance. I'll be happy to answer any questions you have.

Senator METZENBAUM. I would say that the five witnesses we heard this morning were as powerful as any that I have heard in any committee hearing since I have been here. It is rather interesting that there are four other health care hearings that are going on this morning which indicates the degree of interest and concern that Congress has.

This Senator frankly, and I think my colleague to the right of me, are concerned that too much emphasis is being given to the role of the insurance companies, to the role of the American Medical Association, to the role of corporations, and that too little emphasis is being given to the role of the patient and the ability of the patient to get adequate care, and also too little attention perhaps is being given to the right of the physician to be able to participate in the decision-making process, as far as what is needed for the patient. Too much of that decision is being placed at the so-called gatekeeper. As Dr. Rand has mentioned and as Dr. Tooker has pointed out the problems of trying to get somebody, who is totally unqualified, to make a decision as to what kind of medical treatment should or should not be made available to a patient.

Senator Wellstone, do you have——

Senator WELLSTONE. No, you go ahead, Mr. Chairman. I will follow you.

Senator METZENBAUM. Ms. Puhl, would it be correct to say that you were twice the victim of our failed health insurance system—once for becoming sick, and therefore unable to obtain insurance and again, when you were forced on Arizona Medicaid, which did not want to pay for the cost of your treatment?

Ms. PUHL. Absolutely. At least twice.

Senator METZENBAUM. Do you think that low income individuals are particularly vulnerable in managed care health plans?

Ms. PUHL. Well, they certainly are in the State of Arizona. Yes, based on my experience in the managed care system, they are definitely, because you hit the nail right on the head when you said the doctors paid the same—I think it was Dr. Rand who said that—whether or not they see the patient, they are paid the same. And their gatekeeper role is definitely to keep them from seeing specialists. I cannot tell you what a hard time I had getting to see a specialist. I never did see a hepatologist, which is a liver specialist. In 4 years, I could not get a referral.

Senator METZENBAUM. Do you feel that the health care system was sort of making you into something of a nothing?

Ms. PUHL. I alternated between thinking that they were hoping—I got the distinct feeling they were hoping I would just sort of die in one of these bleeds.

Senator METZENBAUM. It would be less expensive if you would die?

Ms. PUHL. It would be less expensive, yes. And the way it ended up was my treatment, of course, they treated me in the hospital so many times. I was in the hospital almost 9 months out of two-and-a-half years. They would have saved a lot of money by giving me a liver transplant or shipping me to a State where I could get one

in the beginning. And there was never any doubt that that was the only procedure that would save my life.

Senator METZENBAUM. Does Arizona have an appeals process? Did you have some place you could turn and say I do not agree with this decision?

Ms. PUHL. I was denied Medicaid on several occasions on some very peculiar technicalities and I always appealed those decisions. But there was no way to appeal. The only way to get a liver transplant on Medicaid in Arizona would be to change the legislation which specifically prohibits liver transplants for adults. The State of Arizona has been sued under age discrimination statutes for that prohibition. The State of Arizona lost.

Senator METZENBAUM. Why did they do it? That is stupid.

Ms. PUHL. My feeling is that they did it—they say that adult liver transplants are experimental. Actually, adult liver transplants are more successful than child liver transplants, so their thinking is backwards. I think they did it because they figure anybody over 21 with liver disease brought it on themselves. I think it is a punitive measure and a cost-saving measure.

Senator METZENBAUM. Unbelievable.

Ms. PUHL. It is unbelievable, especially when hepatitis is the number one cause of cirrhosis of the liver.

Senator METZENBAUM. And that is in the legislation?

Ms. PUHL. Yes, it is, and it has been that way for 11 years. Their income limit was also established 11 years ago. $3,200, I find very offensive. What it does is it makes disabled people like me, totally dependent on their parents or their family. Here I was, I was in my 40's and I had to beg my 84 year old mother if I could to come and live with her because I could not pay my rent.

Senator METZENBAUM. Arizona is a rather forward looking State, but I guess——

Ms. PUHL. My understanding is that the Arizona example variation of Medicaid was quite influential in the drawing up of the Clinton plan. And I think there is a myth that abounds that it is a successful plan. If you were to read the Arizona Republic, which is the biggest paper in the State, you would know that it is not a successful plan. People are constantly grumbling about how much it costs and how many people are disqualified for the plan who should be qualified.

I do not know what the Senate and the House have to do about authorizing these variations, but they funded it at only 50 percent of poverty levels. So you have to be doubly poor. And poor people are not known for their enthusiasm for bucking the system, because they think if they are going to say anything, they will be cut off. And I have talked to many workers for AHCCCS, case workers, and I said, does it not kind of break your heart to deny coverage to somebody like me? I said, you do this everyday, don't you? And they say, yes. I said, well, you are the people who could make a difference with the legislature. Have the case workers say, we see these people being denied coverage because of the rules. But they are afraid they will lose their jobs.

Senator METZENBAUM. Thank you very much. Ms. Smith, it takes a lot of courage in your part to be here today. You are a very gutsy lady. Being the father of daughters approximately your age. I can

tell you how much my heart goes out to you. It is just incredible to me that your health plan could have misdiagnosed three biopsies and two pap smears. That to me is just—it just blows my mind. I mean the stupidity of it, the ignorance of it, the indifference of it.

Are you still having problems receiving proper health care through your HMO?

Ms. SMITH. It is interesting that as part of our medical malpractice suit, we negotiated a contract with them that they were required to provide me with quality care. If two out of three of my treating physicians recommend any type of diagnostic procedure or treatment plan, my HMO is forced through this contract to cover the procedure. That was a necessary step for us because of the quality of care they had delivered before I was diagnosed.

Senator METZENBAUM. Did I understand your testimony to indicate that your HMO contracted out the lab services to the lowest bidder, rather than the lowest high quality lab?

Ms. SMITH. There is no question about that. The owner of the laboratory was on the board of directors for the HMO. And the HMO basically went through a sham in trying to get competitive bids from other laboratories in the area. The lowest bid price that would come in would be given to the owner of the laboratory who was on their board and he would be forced to meet that price in order to maintain the contract. Unfortunately, he could not provide services at that level of cost.

Senator METZENBAUM. And the State did nothing to move in? You come from Wisconsin, a pretty progressive State, and the State did nothing to move in to revoke the laboratory's license or the HMO's license?

Ms. SMITH. The laboratory has since been sold since this happened. I have been working with the insurance commissioner in Wisconsin to see if we can get the HMO disciplined, and at this point, they have said that no specific regulations were violated. There are no regulations in Wisconsin that oversee the quality of care that HMOs provide their patients.

Senator METZENBAUM. I think we have a job to do. I am concerned, as I said previously, that too much of our emphasis is on the cost and whether there will be taxes and what the employers will pay, and too little attention is being given to the question of quality health care. You are just the tip of the iceberg and there are so many more problems. Dr. Rand points out a number of the problems. Dr. Tooker points out problems. Mr. Bosworth indicates they have been pretty close to the system and still have faced these unbelievably challenging problems.

It is just wonderful for you to be here and we just hope that there will be sufficient medical care available to you that you will have a long and healthy life ahead of you. We wish you the best.

Ms. SMITH. Thank you.

Senator METZENBAUM. Mr. Bosworth, both you and your wife are knowledgeable about the health insurance industry. Does it not seem that health care has become a game of hot potato and that no one wants to cover those people who really need it; namely, people who are sick, that if you are sick, we do not want you. If you are well, we want you in our HMO?

Mr. BOSWORTH. At the inception of the HMO industry back in 1973 and even today, I think you will find that the general population that belongs to HMOs, in general, happens to be the more healthy individual. If you just think about when you and I were 20 years old, we were not going to get sick, were we? We were never going to die either. But guess what, now that I am almost 40 and you are probably about 35, I think, Senator. Now we know that that is possible, that we could get sick and we just might die one of these days.

So we always had the younger people in the HMOs, the younger, healthier people. And people that had health problems did not want to go to the HMOs because you had limited access to their physicians. I am amazed listening to these stories. I mean they are just everywhere. I would mention to you that in California, for instance, the Department of Corporations regulates the HMOs in California. We could not really file a complaint with the Department of Corporations because the medical director at HealthNet who did all these horrible things to try to withhold care from my wife, sits on the quality review board of the Department of Corporations and they have these incredible incestuous relationships between the Department of Corporations and the HMOs there. So it does you no good to complain. You are left out on your own.

And as far as we went, we obviously had to file a lawsuit against HealthNet to receive the treatment, and in our case, which was different than the recent $89 million case against HealthNet. We only received the cost of the treatment and I was fortunate to get the attorney's fees out of HealthNet, because of some ERISA legislation that regulates that. But these people are out there. They are negotiating just like you and I may go out and negotiate to buy a car. And it is a nickel and dime thing. Your health and mine is nothing more than a commodity that is bought and sold everyday.

Senator METZENBAUM. We hope we can do something about it. Your testimony was very helpful.

Dr. Rand, what can a doctor do who does not want to join a managed care health plan? Are doctors not under increasing pressure to sign up with these big entities?

Dr. RAND. A physician who does not belong to a managed care plan, today would begin to start looking around to see what he can do in another field or endeavor. If you are not in managed, you are out of work if there are no patients in town that are able to see you. So the problem that an average physician will encounter—and I think I have been getting away with it a little bit longer than some of my colleagues—we have a private organization—we do not have any HMO contracts. The HMOs have come to me and asked me to participate, but I cannot produce quality care for what they offer.

Senator METZENBAUM. What does an HMO say to a doctor when they come?

Dr. RAND. First of all, they refer to the patients as bodies. I will give you 12,000 bodies to take care of. Sometimes they call them heads. And I will give you $3 a month to take care of each of these people. You get $36,000 a month and you take care of them. So my answer to them is I cannot take care of people on a quality basis

that way. Then the HMOs say well, we will find someone who will. Unfortunately, quality is not the issue there.

I know one optical establishment, one of the Medicare HMOs in our area, they all offer eyeglasses as one of the benefits. And he lost the contract because someone else produced the glasses for 5 cents less. They are always moving to the lowest bidder to the lowest bidder. Quality is not an issue.

Senator METZENBAUM. Cost, cost, cost.

Dr. RAND. Right, profit. Not cost, profit, the bottom line. And you ask what does a doctor do? I think you work with them or you do not work with them. And if there are enough patients that you, by your reputation can attract, then you can stay in business. But the truth of the matter is that under the proposed managed competition plans, almost everybody will be in an HMO-type setting. Now a lot of talk has been given to the probability that people will have the option of choice of their doctors. But that is not really so true. The way these plans will be set up, the patient will not have the financial resources to buy an additional level of insurance. Because that is going to be a lot more expensive than what they are getting when they get their HMO plan legislated by the Government.

So these patients, remember like I said before, they do not know to choose, they do not know what a life-shattering decision it is to make, to choose a better level of insurance. They figure I am covered. I am going to live forever. But when they get sick, that is when they find out what limitations they have. If they really knew the limitations and really if they all knew that sooner or later we all get sick and die, Senator. Nobody is immune to this. We all get sick and die and in the end, when we all get sick and die, we are going to depend on the right doctor, being in the right place at the right time, to determine whether or not we are going to be allowed to continue to see or whether we are going to be continued to be allowed to exist.

Senator METZENBAUM. Do you believe that there are any circumstances under which managed health care can provide high quality health care?

Dr. RAND. That is a good question. I have not seen any yet, Senator. From what I understand, the Kaiser situation in California was where the doctors were actually employed by the group. In other words, when you have a group where the doctors function in a defined facility, where they are employed by the group. In the Rand Eye Institute, we employ our physicians. They do not have financial incentive to do a service or not to do a service. But at least they are responsible to a system of quality and ethics.

I think the best way to put it is Kaiser, which I understand now is one that was implicated in that 1989 million dollar lawsuit, so even they may not be so hot. I really, frankly, have not seen a good managed care organization yet.

Senator METZENBAUM. What can doctors and patients do to stand up to these corporate giants and what do you think Congress needs to do?

Dr. RAND. Patients cannot stand up to a corporate giant. Doctors cannot stand up to a corporate giant. We are too small. You can stand up to a corporate giant, because you have the power.

Senator WELLSTONE. We are too small. I am kidding.

Dr. RAND. If anybody has the power, you do, because we delegate you as our representatives to provide not only the leadership, but the collective power of the people. What we need for you to do is to pass legislation that first of all eliminates capitation as a means of paying for medical care. A doctor should not lose money because he wants to make a medical decision on behalf of his patient. You should legislate that antitrust legislation be applied to these corporate insurance companies. They should not be able to buy up insurance company after insurance company. There should be a law definitely passed that says that there should not be interlocking directorates between the supervisory agencies and the boards. And you should not be able to bid it out to a laboratory at the lowest bidder and you should not be able to bid it out to a laboratory that you own.

So the Congress has some difficult issues to wrestle with, but you are the only ones that can do it for us, because we are too small.

Senator METZENBAUM. Dr. Rand, I have been here 17 years. This is my 18th. I was here 1 year before that. In all of that period, I attempted to eliminate the exemption from the antitrust laws that the insurance companies have, and I tell you that I expect I will leave this place and be unsuccessful. The insurance companies own too many Senators and too many Congressmen. I am concerned about how many Members of Congress are owned by the American Medical Association and by other special interest groups around here.

The insurance industry has really done a shameful job. The Met Life situation, Prudential situation, the Executive Life situation and others, have been shameful. And yet my colleagues in this body, present company excepted, are unwilling to deny those same people the exemption from the antitrust laws in this country. The only two industries in this country that are not subject to the antitrust laws are the insurance industry and baseball. And unfortunately, the insurance industry has made a game out of their situation, as well as baseball.

Dr. RAND. But Senator, we live in a real world and politics is the art of what is possible. The fact of the matter is that your insurance company and the insurance industry now own managed care. If I would have come here four or 5 years ago, I would have been complaining about venture capitalists. But they have sold out. They have cashed in.

Senator METZENBAUM. They sure have.

Dr. RAND. The insurance company has bought everything. I had some people from—I will not mention names—but we had one group that came in and wanted to buy the Rand Eye Institute just a couple of months ago. They said we will make it worth your while. You can be working here if you want to. But I said, no. They said, we will be back. We will get you sooner or later. Since that time, they have merged with a huge hospital conglomerate. They bought out rights to almost everything in my area. And the Government, as the unwitting accomplice, is playing into their hands. At least past legislation that prevents the incentives from being in favor of making a profit that way. So it is just capitated care.

Senator METZENBAUM. Thank you. Dr. Tooker, and then I will turn all of you over to Senator Wellstone. Let me ask you, do you

think we need to separate the issue of quality of health care from the issue of reimbursement, so that doctors compensation is not tied to how much or little care they provide? Do you think the capitation method is a negative way of dealing with this problem?

Dr. TOOKER. I do not think there is anything wrong in concept with capitation in the sense of looking at reasonable ways of reducing costs. I mean, one of the reasons we are in this mess in the first place is that health care has been extremely expensive. So in spite of the imperative to provide high quality care, I think we cannot be blind to how much health care costs.

The problem as I see it is the control that the insurer, the HMO has between the doctor and the patient. Neither the physician or the patient has independent control over cost. To me health care should be owned by the consumer. They are the ones that are paying the premium, but they are paying it to somebody who then exerts extraordinary control over both them and the physician that provides the care. So if the patient and the physician agreed with each other that capitation would be a reasonable thing to do, then I could not argue with that. It would be the patient's decision.

But when the HMO and the insurer decides that capitation is the mechanism that becomes a problem, because then they control the utilization of that resource.

Senator METZENBAUM. Good point. Almost 85 percent of the HMOs use some financial incentives to reward doctors for providing less health care. What do you think about those types of arrangements and what needs to be done to ensure that they do not affect doctor's medical decisions?

Dr. TOOKER. From my point of view, patients must have access to their physicians of choice. And a typical example I just had is I have been taking care of a very complicated patient for a long time with a very competent internist and the patient's employer just overnight changed insurers. So the patient came to see me again and I asked him when did you see Dr. X last, and he said well, I cannot see him any more. I said why not? He said because he does not belong to this closed-panel HMO that my employer just changed to.

The patient had absolutely no role in that decision in terms of who his physicians were going to be. And I did not even know that I was acceptable to the other HMO. And he told me, he said, but you are okay. You are on their panel. I did not know I was. Neither the patient nor I, nor his previous physician had any control over who was going to be providing his health care from then on.

Senator METZENBAUM. What is the relationship in the American College of Physicians in the AMA?

Dr. TOOKER. Tenuous. [Laughter.]

Senator METZENBAUM. They are not an integrated whole?

Dr. TOOKER. I want to be quite clear about that. The AMA, of course, covers all disciplines in medicine. As my understanding at last count and falling, that about 43 percent of physicians in this country are members of the AMA and support it financially. The American College of Physicians is completely independent, serves only as an organization representing physicians who practice internal medicine and the related sub-specialties of internal medicine. Since we are both players and AMA is the largest organization in

the country and we are the second largest organization in the country, we meet on a regular basis of issues of common goals. But we are completely independent in terms of our approach to medicine.

Senator METZENBAUM. Thank you very much. Senator Wellstone?

Senator WELLSTONE. Thank you, Mr. Chairman. I will actually try and be relatively brief with each of you. I know we have another panel. First of all, Penny, if I could use first names. I came in in the middle of your testimony and I am sorry to be late. I think really what I want to do almost rather than ask a question is just highlight something you said, just amplify it.

Mr. Chairman, the experience with Medicaid is that there is a tremendous State-by-State variation in terms of defining eligibility and rules of conduct and what not. This, of course, raises an interesting question, as we keep talking about State flexibility. On the one hand coming from Minnesota I see the importance of decentralizing policy and not having it overly centralized and bureaucratized. On the other hand, low and moderate income people are citizens with the least amount of clout, and when I see governors come in and talk about separate Medicaid managed care plans, I get very nervous because all the problems that we have talked about of gatekeeping and keeping costs down, I think are further exasperated when you are dealing with a group of citizens who have the least amount of political clout.

I think this is one of the things that we really have to be very careful about as we talk about, just letting States do it however they want to. I mean, that is where there is a role by way of certain standards that have to be met in order to protect the health and welfare and safety of all citizens. And I just wanted to highlight your point.

And, Karin, I just would say the same thing that the Chairman did. I thank you for being here. I can honestly and truthfully say that I have never been more moved by anybody's testimony and I really hope and pray the bone marrow transplant works out for you. You just seem like the kind of person that is going to just have such strength and such determination.

One point I would like to draw out is, less of a question from what you have said. That is what happens under the President's plan—and if we are not careful who knows where we will end up and I think we might end up in far worse shape—if you have these different plans that people can buy into—an average price plan and a lower cost plan and then people can buy up. Mr. Chairman, this is one point I want you to listen to because I want to try and get your support on this.

I think your point is so important. Even if you have the same package of benefits for each and every citizen, if people can buy into different plans, some of those plans are going to be the kind of plans where you know that that Pap smear test is going to be read correctly. You know it is going to be a really good lab facility. You know your phone calls are going to be returned. You know that it is going to be the best hopefully of caregivers.

And other plans, even if they have the same package of benefits, if they are trying to keep costs down, they are going to cut quality in all sorts of critical ways. And that is why I know that I am going to say in markup and on the floor that Senators and Representa-

tives have to participate in the same either low cost or average plan that we vote for the majority of our constituents, because I think that is the one way we understand what is really going to go on here. We are going to have several tiers of medicine, whatever we say about the same package of benefits.

That is really in some ways what you talked about. Your story is the story of health care. You are speaking for many people and I think we have got to be very, very wary about this stratification and different tiers of health care which give lie to the idea of universal coverage. Universal does not mean just everybody is covered. It means everybody has the same quality care. And I do not think we are there.

I just wanted to emphasize your point, Steven, which is so important about the charge shifting. I call it charge shifting or cost shifting. I think that we are heading down this path right now with what we read the other day in the paper, Mr. Chairman, where, if what the Treasury Secretary proposed is something that is now adopted, companies with 5,000 employees and over can opt out, but any business with 100 to 200 employees to opt out, to self-insure. What you are going to have happen is they are self-insured because they have healthier employees. You know, they are younger. They are healthier employees. And if they are not healthy, or say if their daughter has diabetes, they might not hire them or they might let them go.

So we are not going to be able to regulate this. We are going to have the same cherry picking which we say we do not want to have. And the only way to regulate it would be to create this huge bureaucracy which then will eliminate the very savings we are supposed to have from eliminating bureaucracy. I think that your point about the micromanagement of the caregivers and the cost shifting is hugely important. And I thank you for that.

Now my question, I guess it can be for everyone, but I want to start with two providers, who I could not agree more how managed care could become broken care. There is no incentive for excellence. Only profits could matter. And I wrote down, the bottom line is not the only line. We were talking about the American Medical Association. Let me tell you in Minnesota, the State of Minnesota Medical Association was four votes short at its State meeting of recommending to the State that it study, and I come from a strong "managed care State," that it study single-payer as an option.

And when the American Medical Association met in New Orleans, one of their recommendations to their executive board was to study single payer. I did not say adopt, but to study it. I am not today going to argue the brief for single payer, but it strikes me when I am in Minnesota, there is a story that has not been told. And I am not leaving consumers out. Consumers are a key part of it, but part of that story that has not been told is from the providers or caregivers. It has not been told about where we are heading. This consolidation of power. These mergers are breathtaking in terms of who is taking over here and who manages the managed care.

Many people are demoralized not practicing the kind of medicine they thought they would practice when they went to medical school—so my question for you all is, when you say that we are the

ones, I do not think we are. I really believe—I am not trying to use this as a soapbox, I mean this really sincerely, I think unless we really turn up the heat around the country, and we have a lot of pressure external to the Congress, we are going to be creating, I feel, a real anti-design for quality health care as consumers would define it or providers.

My question, I will start with you, John, is why can we not think of a way of having the providers here in mass or back in the States meeting with their Congressional delegations—I mean in large number—over this very issue of the power of the insurance industry, this micromanagement, and where it is going to take us? I mean, I am telling you now is the time to do it. I would ask you that.

Dr. TOOKER. Being in a State that is close to Canada, I think we are, like you, we are fairly familiar with the single payer. I would say at the present time that it breaks down pretty much along party lines with the single payer which I agree with them staying a part of AMA meeting because it is, in some parts of the country is close to communism, if you would single payer. But certainly in the North it is not.

The beauty of single payer is a concept and I am not sure it is the right system for the country. But the beauty of it is that concept is that it eliminates a lot of the middle process that we are talking about. And in face of it simply, it makes it easy to look at as a concept. The devil though is when that part of the money arrives and the providers have to sit down and fight among themselves about what the distribution of that money is going to be. It will force physicians and other providers to get in the room together which they have never had to do before. They have been able to go along their party lines, such as the AMA has which is taken in a different tactics certainly than the organization has. Although we do have quite a bit in common.

It is going to have to go through a more painful process to force physicians to all come together in the same room to do that. So far that has not happened. A lot of physicians have not seen that things are bad enough from the physician's point of view to force that to happen.

Senator WELLSTONE. The only thing I am saying, and I would like to get the response from all of you, and this is the question for any of you, is I am not even today arguing the brief for a single payer. I could do that for hours and hours and I really believe when it comes to desirability, I do not see any other proposal close to it. But I am not asking for a total agreement on that. But it strikes me that what I have heard today, the one theme that comes out of this is the importance of really humane, dignified, high quality health care for each and every citizen. Consumers should be in the loop. Providers should be in the loop. And we are heading in precisely the opposite direction.

What I am saying to you, I am just simply saying to you all that I think back in each State we have to turn up the heat. I mean some of what Penny and Karin and Steven said is just so powerful. Those are part of the stories from the consumers, but I think the providers could play a really incredibly powerful role. I do not buy the argument that the insurance industry has more power. I think

you have as much power. I think consumers do. We are going to have to start really getting people in gear. I would ask you whether you are up for that?

Dr. RAND. Let me answer that. I think that the media perhaps, to some extent, has painted doctors into a corner where patients do not trust doctors. But they love their own doctor, you know. Everybody knows that if they are in trouble, at least those who are not in the managed care environment yet, they know that if they are in trouble, they will find a doctor who will hold their hand and take care of them and make sure they get the best technology that can be provided.

But unfortunately, the media sort of paints doctors in general and people do not want to listen to us. We are a special interest group. I am not a special interest group. I am a doctor. But when I come and talk individually, I have only limited power. But when the doctors talk as a group, then all the special interest factors come into play.

You know, one of the things that I find that is driving this whole push toward managed care is everyone thinks we are going to bankrupt from health care. I see there was 16 percent of gross domestic product now; 30 percent in 10-20 years, whatever. It is not true. It is just not true. I do not why the point cannot be gotten across. 10 or 15 years from now, Senator, we are not going to be paying for diabetes. We are going to cure that. We are not going to be paying for Alzheimer's disease. We are not going to paying for heart attacks and strokes. We are entering an age of treatment and therapeutics where most of the diseases have consumed so much of our money. And Karin, we are not going to be paying for cancer to the same extent we are paying now.

Certainly 50 years from now, do you think people are going to be dying from cancer? Probably not. So when you see these sharp curves going up, when you see this, you think that it is going to keep going up forever. What you are looking at is the first half of a bell shaped curve. It is up here because now, for the first time in the last 20 years, we can cure cataracts easy. We can cure this. We can cure that. There are a lot of things we can treat. Tests are expensive, but what we are going to see happening now, as the next phase kicks in and we do not have these diseases to pay for——

Senator, in 1900, you would have thought tuberculosis would have consumed the whole national budget within 20 years and we do not pay much for it at all any more.

Senator WELLSTONE. Dr. Rand, I will just finish so we can move on. The only response I would have, and I do not know that you and I would agree on all the issues, especially in relation to cost control and cost containment, and what I think we probably do need to do. But when you said and I have heard this from so many doctors in Minnesota—so many, it is unbelievable—when you said the problem is that we are in a bit of a box because when we speak up people say well that is because he or she, they are interested in making $500,000 year.

But I am saying, I think it ought to be the consumers—I mean, I think in a joint kind of gathering with consumers and caregivers together is where we ought to do it. And I really believe it is time,

just as Karin and Penny and Steven have really come here and you have too, but I think back in the States, we really need your voice now. And I am just leaving it at that for now, because I think we are going to try to do a lot of organizing around the country, but I think the consumers, the providers, the caregivers are there and can really have a powerful voice. And I am just hoping that—because otherwise, it is like the words of Rabbi Hillel, if not now, when? Anyway, thank you.

Senator METZENBAUM. With that it is appropriate, not now, when, to change our panel and go to the next one. Thank you very much, incidently, you have been an extremely impressive panel. And to you two ladies, we wish you the very best of health. Thank you.

Our next panel consists of Sara Nichols, Staff Attorney, Public Citizen; Gail Shearer, Manager, Policy Analysis, Consumers Union; Geraldine Dallek, MPH, Center for Health Care Rights, on behalf of the Coalition for Consumer Protection and Quality in Los Angeles; and David Lyons, Vice President, National Association of Insurance Commissioners, who is himself the Commissioner of Insurance for the State of Iowa. Thank you. We look forward to hearing your testimony. Sara, we will be very happy to hear from you first?

STATEMENTS OF SARA NICHOLS, STAFF ATTORNEY, PUBLIC CITIZEN'S CONGRESS WATCH, WASHINGTON, DC; GAIL SHEARER, MANAGER, POLICY ANALYSIS, CONSUMERS UNION, WASHINGTON DC; GERALDINE DALLEK, MPH, CENTER FOR HEALTH CARE RIGHTS, ON BEHALF OF THE COALITION FOR CONSUMER PROTECTION AND QUALITY, LOS ANGELES, CA; AND DAVID LYONS, VICE PRESIDENT, NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS, COMMISSIONER OF INSURANCE, STATE OF IOWA, DES MOINES, IA

Ms. NICHOLS. Thank you Chairman Metzenbaum and the members of this committee for allowing me to testify today.

My name is Sara Nichols and I am a staff attorney for Congress Watch, the legislative advocacy arm of Public Citizen. Public Citizen is a national consumer organization with over 160,000 members nationwide. I am here to speak to you today about managed care, who controls it, who benefits from it and because of this, how would it affect consumers if we rapidly increase managed care enrollment as the basis for reforming our health care system?

My task today is to lay out for you the structural reasons that Public Citizen is troubled with the use of managed care as a building block for reform. It is a primary reason we oppose managed competition, and favor instead, a single-payer system that does not rely on managed care as the route to reform. We understand that there are excellent managed care facilities in this country. I myself was quite satisfied growing up in the Kaiser Permanente system of California. And we can identify many problems with traditional fee-for-service medicine. Our concerns are not with the exceptions, but with the rule.

Public Citizen has examined managed competition closely in all its various forms and we are opposed to it. We find the structural basis for managed competition to be anti-consumer and consider it impossible to produce reform using that structure.The flaws of

managed competition are the same whether in the most public, government-controlled version, the pure market-based version, or whether the version is somewhere in-between like President Clinton's plan.

Among its other problems, instead of removing a layer of bureaucracy from our health care system by moving to a single payer which replaces the inefficient private insurers with the government as the sole payer of health claims, managed competition mandates for most of the population two new layers of bureaucracies between the patient and doctor: the health alliance, and the managed care bureaucracy.

Likewise, the noble goals of the President's health care plan are subverted by the anti-consumer structure he has chosen. Unfettered use of health care services by consumers is not the reason our health care system is so expensive. In fact, we go to the doctor in this country less than any other industrialized nation on earth. So to design a system based on deterring consumers from seeking care won't work and hurts consumers rather than helping them. In short, we do not like managed competition because, by its very nature, it preserves and rewards the most wasteful interests in our current system, namely, the health insurance giants and unfettered private hospitals, while it punishes consumers by blaming them for the high cost of health care.

To the President's credit, the Clinton Health Security Act devotes hundreds of pages to put elaborate mechanisms in place which lessen the cruel effect of managed competition on the consumer. But this exercise is a waste of time because it is an impossible task. The only known way to achieve our shared goals of universal coverage, choice of provider, simplicity and security is through a single payer system. This is why we support the American Health Security Act, S. 491, introduced by Senator Paul Wellstone, along with the Chairman of this subcommittee, and a member of the full committee, Senator Paul Simon.

The two main points I wish to make about managed care today are as follows:

A. The delivery of medical care in America is moving away from a closer relationship between doctors and patients to one of corporate mediation of the doctor-patient relationship. Over the past ten years, enrollment in all forms of managed care plans has more than quadrupled, rising from 10.2 million enrollees in 1982 to 41.4 million enrollees in 1992.[1] The trend toward increased managed care in this country is a trend toward corporate and, in particular, insurance domination of health delivery. Managed competition would greatly accelerate that trend, assuring corporate rather than consumer and provider control of medicine.

B. While more people are members of Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Individual Practice Associations (IPAs) than ever before, the response of consumers to the quality of this medical care has been mixed, at best. The fundamental basis for managed care is that a health plan monitors, manages, and controls the access to health services to constrain costs and limit unnecessary hospitalizations

[1] Patterns in HMO Enrollment, Group Health Association of America, 1993.

and procedures. While the aims of managed care are laudable, as consumers, we are concerned that delivery of care in this manner may sometimes be at odds with the quality of medicine consumers receive. As such, while managed care may be a useful part of our health delivery system, it may not be sufficiently successful to warrant the virtual mandate by managed competition for all Americans to join managed care facilities.

II. CORPORATIZATION OF CARE

A. For-profit HMOs Are Growing

Between 1986 and 1989, corporate ownership of managed care plans surged from 50 percent to 66 percent nationally, according to research by Marion Merrell Dow.[2] The big insurance companies like Aetna and CIGNA, for-profit enterprises like Humana, and large managed care firms like U.S. Healthcare are increasingly purchasing or managing local managed care plans and facilities.

A recent study by Marion Merrell Dow found that 21 of the 25 fastest-growing HMOs were for-profit, and that the eight largest firms (Blue Cross, CIGN'A, Aetna, Travelers, MetLife, Prudential, Humana, and United Healthcare) own 251 of the 562, or 45 percent, of the HMOs in the country.[3] Only these health care conglomerates have the capital to finance corporate takeovers. The rising concentration in the managed care industry of for profit companies prompts questions of whether such changes produce quality medical care, lower costs, or other desired results of health care reform.

B. Managed Care Profit May Be Profiteering

For the past several years the managed care industry has been earning a hefty profit. Both companies and stockholders gained during the eighties. In 1990, the HMO industry earned $1.39 billion before taxes, and in 1991, 82.8 percent of HMOs were profitable or earned a surplus.[4] In 1992, the stock values of 16 HMO companies tracked by Furman Seltz Inc. gained 80 percent on average, some nearly tripling in price.[5] Between 1989 and 1992, CIGNA had an annual net income average of $413 million, Aetna $463 million, Humana $260 million, MaxiCare $160 million, Prudential $202 million, and U.S. Healthcare $114 million according to SEC records.

The problem with moving toward a for-profit health care system may not at first be obvious. After all, the profit incentive is widely touted as a panacea for the ills of the health delivery system. However, the recent shift toward profitmaking in managed care may have actually exacerbated the problems in our system, diverting dollars from care to overhead. To date, the market-driven health care delivery system has been unable either to control costs or guarantee access to care. This is not surprising, since for-profit health care delivery tends to restrain delivery of services to maximize profits.

The insurance companies, for example, earn profits by paying less in claims than they receive in premiums. To optimize profits, insurers have increased the costs of their products and limited

[2] For Profit HMOs: Unmanaged costs, Public Citizen Health Letter, October 1991.
[3] Marion Merrell dow, managed Care Digest, HMO Edition 1993.
[4] Business Insurance, December 15, 1992.
[5] Business Week, July 12, 1993.

their willingness to pay for and cover services. The companies have traditionally gamed the system by excluding previous conditions, canceling coverage for the seriously or chronically ill, and cherry-picking the healthiest customers.

Even under a system of mandated coverage it appears likely that insurance companies will exclude consumers to generate earnings. Bob Hunter, the former President of the National Insurance Consumer Organization (NICO), now the Texas State Insurance Commissioner, reports that in states where auto insurance is guaranteed, like California, insurers avoid the inner cities. They claim to "lose" applications, and say they are unable to "find" their Spanish forms.[6]

There is nothing to indicate the market forces at work in the managed care industry will behave differently. Advertising and marketing costs, for example, are the engine of competition in managed care. To encourage consumers to "vote with their feet," firms market their products and aggressively advertise their services.

For-profit enterprises appear to spend much more on advertising than not-for-profit firms. These marketing costs represent funds which could be spent instead on delivery of care. In New York City, U.S. Healthcare spent more than $12 million on marketing in 1991, amounting to 19.1 percent of what it spent on hospital care. On average, for-profit firms in New York City spent $55.83 on advertising per member compared to $10.86 spent by not-for-profit groups in 1991.[7] The marketing costs incurred by for-profit firms generate more enrollees, but also divert money from providing necessary care.

Certainly, any tendency to devote an increasing percentage of overhead to advertising and marketing costs would only be accelerated in a managed competition-based system where HMOs must convince not only employers, but individual consumers, to enroll in droves. Advertising and marketing costs would be one of many factors in managed competition driving up the cost of care rather than bringing it down.

C. Lack of Cost-Savings

The size of the profit in the for-profit managed care industry calls into question the quality of care in the facilities and networks. Moreover, since there is little indication that managed care is keeping over-all costs down, the profit may be at the expense rather than for the expense of providing care.

Recent studies from the GAO, CBO, and the Health Care Financing Administration have shown no overall savings from managed care. An A. Foster Higgins survey found that, for 48 per cent of employers, managed care premiums were as high or higher than indemnity premiums.[8] In California, one-third of the people are covered by managed care, but costs are 19 percent above the national average and rising more rapidly. Massachusetts and Minnesota, the second and third highest states for HMO enrollment, have similar cost records. According to a recent GAO study, "Although many employers believe that, in principle,managed care plans save

[6] NICO Newsletter, vol. xi, nos. 3 and 4, May through August, 1993.

[7] "Vital Signs: What the HMOs Don't Tell You That You Need To Know," City of New York Department of Consumer Affairs, April, 1993.

[8] Washington Post, August 30, 1993.

money, little empirical evidence exists on the cost savings of managed care."[9]

While high profits, if they coincided with cost controls, could be heralded as a success of the market-based health care system, the reverse is true here. High profits coincide with rising costs leading one to the conclusion that the companies are not only profiting but profiteering at the expense of the consumer.

D. Concentration in the HMO Market

Although enrollment in managed care plans is steadily increasing, a few larger firms are controlling the majority of the managed care market. The ten largest managed care companies serve 44.1 percent of the national enrollment.[10] These firms wield enormous market power, have a steady stream of income from their plans, and are shaping the future of American health care delivery. Five of the ten largest managed care enterprises (Aetna, CIGNA, Kaiser, MetLife, and Prudential) were participants in the influential Jackson Hole Group which helped to design managed competition proposals.

President Clinton's managed competition plan is intensifying the flight toward managed care. Along with the insurance companies, teaching hospitals and for-profit hospitals are creating managed care networks or expanding the ones they have. Recent headlines include "Clinton's Health Plans are Likely to Step Up the Switch to HMOs,"[11] "Health Industry is Moving to Form Service Networks,"[12] "HMOs See Glory Days Under Clinton,"[13] and "Managed Competition May Benefit Chains."[14] The Business Insurance prediction after the 1992 presidential election was bullish, writing, "[a]n already thriving HMO industry could be a big winner if the health care delivery is overhauled as promised by President Clinton."[15]

The largest HMO chains are spread out across the nation, with many plans in many states. As of April, 1993, CIGNA owned 42 plans in 27 states, Prudential owned 28 plans in 18 states, Aetna owned 25 plans and manages an additional 3 plans in 19 states, MetLife owned 14 plans in 14 states, Travelers owned 9 plans in 9 states,[16] Humana owned 17 plans in 10 states, and U.S. Healthcare owned 7 plans in 6 states.[17]. A September, 1993 study by Marion Merrell Dow shows that all of these companies except Aetna own even more HMOs today than they did in April, with MetLife growing from 14 plans to 25 in that short time.[18] Under managed competition, it is almost exclusively companies like these who will be able to move in to fill the needs of the new system. This will virtually assure domination of the managed care system by an oligopoly, rather than a true competitive field.

---

[9] Government Accounting Office, "Managed health Care: Effect on Employer's Costs Difficult to Measure," October, 1993.
[10] Group health Association of America, Patterns in HMO Enrollment, 1993.
[11] Wall Street Journal, May 18, 1993.
[12] New York Times, August 21, 1993.
[13] Business Insurance, December 15, 1992.
[14] Modern Healthcare, January 4, 1993.
[15] Business Insurance, December 15, 1992.
[16] Group Health Association of America, Patterns in HMO Enrollment, 1993.
[17] Group Health Association, 1993 National Directory of HMOs, June 1993.
[18] Marion Merrell dow, Managed Care Digest, HMO Edition 1993.

Although the managed care and insurance chains claim to be at a competitive disadvantage to-the smaller, community-based managed care facilities and networks, the reverse is true. There has been a trend of consolidation in the industry, and many managed care plans have been swallowed in mergers and acquisitions. Since 1987, the enrollment in HMOs has skyrocketed from 31.0 million members to 43.7 million members—a 40.9 percent increase, while the number of managed care plans has fallen from 707 to 562—a 20.5 percent decline.[19] According to the Marion Merrell Dow study, the 48 national HMO chains enrolled 36.7 million members, an astounding 84 percent of all enrollees.[20]

In the traditional indemnity insurance market, the insurance industry's exemption from antitrust laws has tacitly permitted collusionary pricing schemes. The increased concentration of the managed care market, rather than generating intense competition between a few players, is instead likely to create an industry oligopoly.

According to American Enterprise Institute's Health Policy Studies Director Robert Helms, the Clinton plan is likely to create cartels of health plans within alliances which would have little incentive to provide premium bids lower than average bids. At a Heritage Foundation conference on January 19 he said, "[e]xcessive competition on the basis of price or quality would be highly discouraged—if you're going to be a good cartel member, you shouldn't rock the boat in terms of making things tough for your competitors.[21]

This "managed cartel" will have incentives to increase prices rather than lowering them. In this manner, they can enlarge the health care pie, securing each of them a bigger share of it. Naturally, this behavior will tend to raise the cost of health care, rather than lowering it.

E. The Alliance for Managed Competition

Dominant among the fastest-growing owners and operators of managed care facilities and plans are the large insurance giants, Aetna, Metropolitan, Prudential, the Travelers, and CIGNA—known collectively as the Alliance for Managed Competition. The general trend toward managed care, as accelerated by the political possibility of managed competition, dramatically shifts insurance companies from processing claims and bearing the risk of loss to assuming near total control of the health delivery system as the owners and operators of HMOs. The business changes facing these large insurers are predicted to be beneficial. Bill Link, Executive V.P. at Prudential wrote in an internal newsletter, "For [Prudential] the best case scenario for reform -preferable even to the status quo—would be enactment of a managed competition proposal." The mere fact that the largest insurance companies have formed an alliance to push for managed competition is evidence that they will profit from its enactment.

Not surprisingly, the Alliance for Managed Competition has tacitly endorsed the Clinton plan. It has launched an advertising campaign touting its five members (also known as "the Big Five ") as

---

[19] Marion Merrell Dow, Managed Care Digest, HMO Edition 1993.
[20] Ibid.
[21] Health News Daily, January 20, 1994.

the real reformers of the health care system including "On Health Care Reform We Agree With America's Governors," "Top 10 Reasons Why Americans Will Have More Choice of Health Care Providers Under Market Based Managed Competition," and "Sometimes We're Bashful—So We'll Let Someone Else Explain What We're About" which says "Health care reform has many friends. Let's bring them together for the sake of the American People."

Sadly, the Alliance is pushing reform for the sake of its own profits at the expense of American consumers. The Big Five hold enormous portfolios of managed care facilities and networks. Aetna is currently building family medical clinics and staffing them in Atlanta, Charlotte, Chicago, Dallas, and Washington,[22] a feat a smaller firm would be unable to accomplish. These products are also extremely profitable for members of the Alliance. CIGNA earned a $30 million profit from its managed care products in the first half of 1992 alone.[23] The mere fact that the largest insurance companies have formed an alliance to back managed competition is evidence they will profit from it.

Meanwhile, the executives who endorse the drive for managed competition are already reaping tremendous awards from the trend to managed care, and see brighter futures under managed competition. According to SEC records, Ronald Compton, CEO and Chairman of Aetna, earned $851,737 in 1992; Wilson Taylor, CEO, President, and Chairman of CIGNA earned $2.39 million; Lawrence English, Division President of managed care products at CIGNA, earned $1.17 million; and Edward Budd, CEO and Chairman of the Travelers, earned $923,000.

F. Corporate and Insurance Domination of Health Alliances

While the concentration of the managed care industry poses problems to Americans today, under the potential managed competition of tomorrow, the larger, wealthier firms will increasingly dominate local health care delivery. The proposed health alliances, which would monitor and regulate health plans, will have a giant task in controlling managed care plans owned by a handful of mega-corporations. The volume of data collection required to provide adequate oversight alone is enormous. To produce sufficient information for consumers, alliances will have to collect information on a wide variety of indicators, from quality to cost.

This task could prove impossible. The Federal Employee Health Benefits Plan (FEHBP) has a similar duty to provide information to its members on price and service and has been unable to release understandable information to enrollees. Because of the difficulties of this task, the reality is that the Office of Personnel Management, which has never helped to provide quality and cost information, has merely published the information the insurers provided without providing independent analysis or compilation.[24] Moreover, FEHBP has averaged double digit rate increases since 1984, rising faster in the Eighties than overall health care costs. Since FEHBP requires employees to bear additional costs for better

[22] Wall Street Journal, October 13, 1993.
[23] Business Insurance, August 31, 1992.
[24] NICO Newsletter, vol. xi, nos. 3 and 4, May through August, 1993.

plans, like the Clinton plan, a predictable multi-tiered system has emerged; higher income workers have better health plans.

The actuarial, medical expertise, accounting, and statistical needs of the alliance will also have to be filled, and it is certain that to do so, the alliance will have to turn to the insurance industry for help. We expect that the data and staffing needs of the Alliances could only be fulfilled by people from the insurance industry. Even Ira Magaziner has said some of the staff could come from the small insurers forced out of business by managed competition. Already, insurance companies have a large influence over state regulators, and since health alliances will need the cooperation of the industry, there is a real risk that the alliances could become industry-dominated.

G. Citizen Input

Though we fear industry domination of health alliances is virtually inevitable, there are some protections worth instituting, whether in a single payer or managed competition system. At a minimum, consumers need to have a strong voice to combat industry's demands. Independent, private sector health watchdog groups, which would be voluntarily-funded and citizen controlled, should be chartered and facilitated through government mailings to consumers to represent the needs of individual consumers in each Health Alliance. The watchdog would collect data, monitor regulatory changes, testify before medical boards, represent consumers in grievances, and provide information to consumers on political and industry attempts to change the system.

III. MANAGED CARE IS ANTI-CONSUMER IN CONCEPTION

A. Consumer Satisfaction

Recent consumer surveys seem to bear out the no-ion that consumers are less than fully satisfied with HMOs. The data indicate that not only are patients unsatisfied with the care they receive from managed care plans, but that they like independent practitioner settings more than any type of managed care.

A recent Johns Hopkins University study in the Journal of the American Medical Association compared HMOs, networks (like IPAs and PPOs), and independent practices in Boston, Chicago and Los Angeles and found patient satisfaction to be universally higher under independent practice settings. A sampling of providers from each practice setting surveyed patients over nine days in 1986. Overall, less than half of all managed care patients rated their care excellent compared to 65o? in independent fee-for-service practices. This disparity was exhibited in all facets of care from appointment schedule delays (40 percent excellent in HMOs to 65 percent in independent fee-for-service) to telephone access (33 percent excellent in HMOs to 64 percent in independent practice).[25] On the whole, consumers are markedly less satisfied with managed care services than independent practices.

Widespread consumer dissatisfaction is an indication that the quality of care delivered at managed care practices and facilities is below patient expectations about health care delivery. Patient atti-

[25] Haya R. Rubin MD, PhD et al; Patients Ratings of Outpatient Visits in Different Practice Settings, Journal of the American medical Association, August 18, 1993.

tudes, however, only demonstrate how the mechanisms of managed care can act to curb the quality of care on an individual basis. The underlying problem, however, is managed care puts perverse incentives on doctors and administrators to control costs by limiting access to necessary care instead of cutting waste out of the managed care system itself. This flaw worries us because it indicates that managed care may not make sense as the sole basis for health reform. Decisions about what resources to allocate where and how many health services we can afford should be made on a community-wide level. They make no sense if applied only to individuals.

B. Physician Remuneration

Increasing provider incomes and fees contribute to overall medical expenses and inflation. Managed care plans have sought to constrain those costs by moving away from the traditional fee-for-service payments because they create incentives for physicians to overuse medical services. While there are fee-for-service style managed care plans, they are generally more expensive and have comparable problems with overuse and costs as indemnity fee-for-service plans.

Many managed care plans pay their doctors a monthly capitation fee for each plan member served. Employers pay the plan a fixed amount each month to cover their employees, and the plan pays the providers based on the number of enrollees. This dissuades doctors from overusing services to increase their income. However, capitated pay schedules can easily discourage the delivery of care. The doctor is paid a fixed fee regardless of the number of patients who visit the office. These plans have an incentive to provide as little care as possible to the enrollees. Since the plan is paid a set monthly premium from the employer, any care which is not provided is profit for the plan. In practice, the scheduling delays, office waits, and difficulty in contacting the providers by telephone which HMO members reported are ways managed care plans may create an atmosphere which discourages the use of health services. This environment may benefit the HMO, but it hurts the consumer.

Additionally, some plans reward physicians who make fewer referrals to specialists. Either annual bonuses are awarded based on the number of referrals a doctor makes, or a portion of provider income, usually 15–20 percent, is withheld in an escrow fund and returned only if specialist referral targets are met. The Department of Consumer Affairs in New York City found that 8 of 13 managed care operations in the metropolitan area used some form of withholding or bonus in paying their providers.[26] Managed care plans are attempting to keep costly specialist visits to a minimum, but these bonus and withholding policies create an explicit disincentive to give patients access to specialists. It is a clear example of managed care's cost containment strategy being directly opposed to the goal of providing quality care. Doctors may be forced to choose between their livelihood and providing necessary care and access.

C. Utilization Review

Utilization review is the cornerstone of managed care. It is the oversight mechanism of the plans on the doctors and patients. Utilization review departments within managed care plans monitor,

---

[26] City of New York Department of Consumer Affairs, Vital Signs: What the HMOs Don't Tell You That You Need to Know, April, 1993.

evaluate, and approve the procedures of physicians and other providers based on the condition and needs of the patient. Utilization review processes weed out extra days of hospitalization, unnecessary specialist references, and limit diagnostic tests. In theory, utilization review cuts down on unnecessary procedures and prevents cost escalations coming from overuse of medical services by plan members.

In practice, however, utilization review may limit necessary procedures as much as unnecessary ones without regard to whether the total system can afford those procedures. Certainly, if we are to control costs, we may have to get to the point of limiting care, but that decision should be a last resort, not a first resort mechanism. Utilization review relies on top-heavy administrative costs, from 10 to 18 percent of premiums compared to 4 to 12 percent of premiums for indemnity insurance[27], to offset health care costs and it is not at all clear that the savings occasioned by such oversight outweighs the financial and quality cost of second-guessing physicians.

Anecdotal evidence and press accounts suggest there are situations where utilization review procedures prevent enrollees from acquiring necessary and vital care. The majority of these disputes between plans and patients arise over billing reimbursement questions. When members seek emergency care outside the geographic limits of the plan or seek specialist services recommended by their primary care doctors but unapproved by the plan utilization reviewers, managed care plans will occasionally cover only a portion of their customary reimbursement.

While failure to pay for needed care may be potentially financially ruinous to a patient who believed the procedure would be covered, it is not life-threatening. Unfortunately, there are also accounts of fatal utilization review decisions.

For example:

—Florence Corcoran's baby died after a utilization review company refused the prenatal hospitalization which was recommended by her doctor. Her claims against United Healthcare Inc. have been fruitless as the Fifth Circuit ruled that ERISA does not permit ordinary liability claims by the beneficiaries of plans it governs.[28]

—Buddy Kuhl's doctor recommended that he receive special surgery at Barnes Hospital in St. Louis after he suffered a heart attack in April. His HMO wanted to keep Mr. Kuhl within their network and asked for a second opinion; the second doctor also recommended that he go to Barnes. Mr. Kuhl scheduled the operation at Barnes for July on the advice of two doctors, but his Lincoln National HM0 wanted yet a third opinion which was made on the same day as the scheduled surgery. The third doctor also recommended the surgery so Lincoln National relented, but the surgery was postponed by Barnes until September. In September Mr. Barnes' heart was too weak to survive the operation and he died in December.[29]

—Nalene Fox was diagnosed with breast cancer in 1991, and after other treatments failed, her physician recommended a bone

[27] Consumer Reports, "Health Care in Crisis: Are HMOs the Answer?," August, 1992.
[28] Wall Street Journal, November 25, 1992.
[29] Money, April, 1993.

marrow transplant in June 1992. Her HMO, Health Net, the second largest HMO in California, refused to cover the transplant because it was deemed experimental. The friends and family raised the $150,000 for the operation by August of 1992, but the procedure was performed too late to save her life. She died in April of 1993. Her family won an $89.1 million dollar suit against Health Net.[30]

Although utilization review is supposed to limit unnecessary surgeries and procedures, there is evidence that managed care has higher rates of some surgeries than is optimal. A study by the RAND Corporation found that only 58 percent of hysterectomies performed in HMOs were appropriate, 25 percent of them were performed for uncertain reasons, and 16 percent were inappropriate. The rates of inappropriate surgeries varied among the seven plans studied. From 10 percent to 27 percent of the hysterectomies performed were unnecessary. In comparison, AID cites a 1989 study of the Naval Hospital in San Diego which found only 5 percent of the hysterectomies were inappropriate.[31]

IV. CONCLUSION

The corporatization of health care is a direct result of increased reliance on managed care in the health delivery system. This increasing amount of corporate domination of medical decisions is already occurring as we speak but would be sharply accelerated by a move to managed competition.

Profiteering at the expense of health care, high advertising and marketing costs, and industry control of health alliances are all likely results of a managed competition-based health care system. These results are not aberrations, fixable by tinkering with the size or composition of the alliance or premium caps. Rather, they are the inherent predictable result of attempting to restructure our health care system by putting the very corporations most responsible for the skyrocketing costs in our current system in charge of the restructuring.

Still and all, these negative effects might be worth it if we had any indication that managed competition would work, that it would control costs sufficiently to deliver health security to the currently uninsured. But, while it is outside the scope of this testimony to explore why managed care will not control costs, it is clear that it will not.

The only system which we know cuts costs enough to deliver comprehensive health coverage to all Americans is the single payer health care system. Certain validated elements of managed care could be a part of a single payer system, but it would only thrive if people chose to go to HMOs over a traditional independent practitioner. In contrast, managed competition cannot exist without forcing consumers into managed care plans.

Congress should enact a single payer health care system based on the Canadian system like S. 491, the American Health Security Act. In such a system, competition in health care truly benefits the

---

[30] Washington Post, December 30, 1993.

[31] Steven J. Bernstein, MD, MPH, The Appropriateness of Hysterectomy: A Comparison of Care in Seven Health Plans, Journal of the American medical Association, May 12, 1993.

consumer. Competition is between doctors on the basis of efficiency and quality of care rather than between health plans on the basis of price.

25 Ways to Make A Good Plan Even Better

Recommended Changes to the Health Security Act

Consumers Union

1. Make the benefits provided by health plans truly standard. Require all health plans in any regional alliance to have the same treatment protocols, including policies toward experimental treatments.
2. Require the alliances to handle disputes and appeals for denied treatment.
3. Integrate all segments of the population into a single system with a global budget within five years.
4. If market conditions warrant (an area has too few high-quality, low-cost health plans available), require alliances to create a Medicare-buy-in type of option that allows consumers to get coverage outside of the insurance industry.
5. Expand benefits to include nursing home care, expanded home care, more extensive mental health care, and care for children with congenital problems.
6. Require that alliances limit fee-for-service plans to one in order to achieve administrative cost savings and avoid risk selection problems.
7. Limit the difference in cost between fee-for-service plans and the average premium plan so that low- and middle-income consumers can enjoy freedom-of-choice of health care providers. (This is especially important for migrant workers.)
8. Protect low-income consumers by reducing the portion of income that must be spent on premiums to 2 percent, by expanding the premium discount for low-income consumers, and by reducing or eliminating the cost-sharing required of low-income persons.
9. Standardize the supplemental benefits market.
10. Provide the National Health Board with authority to regulate—and roll back—prescription drug prices.
11. Give the National Health Board the authority to set minimum quality and access requirements for health plans.
12. Eliminate the antitrust exemption that allows doctors to rig bids.
13. Modify the medical malpractice reforms so that they serve consumers' interests.
14. Establish a national guaranty fund for health plans. This fund would pay outstanding policyholder claims in the event of company insolvency.
15. Regulate health plan finances to protect consumers. Specifically, expand federal capital and surplus standards to cover all health plans and health alliances; health plan assets should be separate from the rest of a company's assets. Antitrust laws should be extended and exemptions should be limited to prevent companies from using predatory pricing practices in non-health portion of business to bolster health plan business.

16. Expand counseling programs (that now serve senior citizens) so that all consumers have access to an objective source of advice about selection of health plans.

17. Improve the regulation of the private long-term care insurance market.

18. Exempt low-income senior citizens (those earning up to about 150 percent of the poverty line) from the increase in the Medicare Part B premium.

19. Provide for nationwide risk adjustment, so that the costs associated with high-risk populations are spread fairly. This is the only way that small groups of high-risk populations (who may be grouped within one regional alliance) will not pay disproportionately higher premiums. In addition to health problems, risk adjustment should include non-health related factors that can restrict access to health care, such as transportation, translation, and other related services.

20. Adjust the subsidy for early retirees so that those with incomes substantially above the poverty level pay their fair share of health care costs.

21. Ban hospital indemnity and dread disease policies.

22. Ban variations on the standard benefit package.

23. Require insurance companies to have legitimate consumer representation on boards; expose insurance company executives' salaries to public scrutiny.

24. The plan should be consistent in how it deals with supplemental insurance policies designed to cover cost-sharing, or the out-of-pocket expenses a consumer would face. Either this coverage should be banned across the board, or it should be allowed under both low cost-sharing plans and high cost-sharing plans.

25. Impose an income tax surtax, a tax on new hospital revenues that are created by reduced spending for uncompensated care, and increase the tax on corporate alliances to pay for additional benefits and subsidies.

Senator METZENBAUM. Thank you very much.

Gail Shearer, Manager of Policy Analysis, the Consumers Union?

Ms. SHEARER. Thank you, Mr. Chairman. Consumers Union appreciates the opportunity to present our views on the need for consumer protection in a reformed health care system. Members of this subcommittee and you two Senators, in particular, have worked for years for health care reform. I know that neither of you needs convincing about the fact that there truly is a health care crisis, especially in light of the compelling testimony that we have heard this morning.

In conjunction with the campaign for health security, we have recently released two reports that show how the health care crisis affects people at both ends of the age spectrum—seniors and children. Despite Medicare coverage, seniors suffer in the health care system because they cannot afford prescription drugs or the high cost of long-term care. They have restricted choice of doctors with low Medicare reimbursement rates, and decreased doctor willingness to accept them as patients. They are forced to use their limited funds to pay their hospital deductible and their 20 percent copayment. 8.3 million uninsured children and their parents know there is a health care crisis.

Insurance policies regularly exclude the all important well baby and well child checkups. They rarely cover immunizations such as measles' shots that can prevent chronic, serious illness. As families struggle to work their way out of poverty, they often find that they lose their Medicaid eligibility and the health care that their children so desperately need. The Nation urgently needs health care reform.

Only two bills, the single-payer bill which you both support, and the Clinton bill stand head and shoulders above the other five major proposals in terms of meeting consumers health care needs. We do not believe that so-called reform, which is voluntary, will come close to providing health care security for all. And indeed, we are troubled that Congress does not seem to be moving in the direction of recognition of this point. Nor do we believe that the Nation will be able to pay the bill for health reform unless employers are required to make a substantial contribution toward the cost. Furthermore, legislation that counts you as insured if your family faces a $3,000 deductible is not the type of reform that consumers need.

In my statement, I plan to summarize Consumers Union Five/Five Plan—five important provisions of the Health Security Act that should be preserved against the forces of powerful special interest and five provisions that should be modified to better serve consumers. There is one particular area that needs some attention and that is the need to make the plan more accountable to consumers, not insurance companies or HMOs' bottom lines.

The following five provisions must be preserved. First, universal health care must be a reality within the next three or 4 years. 79 percent of respondents in a Gallup Poll this week said that they favor reform that provides guaranteed health care for everyone.

Second, cost containment through limits on public and private spending must be kept. It is too late to leave cost containment to the free market. It has not worked. It will not work.

Third, employers must be required to contribute to the cost of their employees' health care. Employers will be paying premiums totalling $185 billion this year. Without a mandatory employer contribution, Congress will simply not be able to find the funds to pay for a universal program.

Fourth, keep the benefits comprehensive. Consumers want and need comprehensive benefits. We should not create a multi tiered system that leaves poor with bare bones coverage, while granting the wealthy full coverage through a supplemental market with regulatory challenges of its own, similar to those of the Medigap market that you corrected in 1990.

Fifth, maintain the State single-payer option. If adopted nationwide, the Congressional Budget Office projects health care savings of $114 billion in 2003. This is the best value reform for consumers. At least let the States have that option.

The most important areas to fix are first, protect low and middle income consumers from facing financial barriers to care or burdensome premiums. Second, increase accountability to consumers, and I will expand on this in a moment. Third, make freedom-of-choice of provider a real option for people of all income levels. Fourth, include the blueprint for phasing in nursing home benefits and expanded community care benefits. And fifth, give the National

Health Board the authority to regulate prescription drug prices that apply to all Americans.

If drug prices were a river, they would already be well above flood stage. It is meaningless to talk about jawboning through voluntary price controls, since prices are already so out of line. And I call to your attention the two reports that have come out this week. Yesterday, the General Accounting Office released a report showing American consumers are footing the bill for the world's consumers by paying 60 percent higher costs for prescription drugs than their counterparts in England. Senator Pryor released a report earlier this week that also showed drug prices continuing to increase faster than inflation.

I would like to comment briefly on the need for increased accountability to consumers in the Health Security Act. Our first choice solution for health reform would be to eliminate insurance companies all together with a single-payer system. In the absence of that, insurance companies should at least be held accountable to consumers, rather than their bottom line profitability. First, insurance companies should be prohibited from varying the benefits offered within each alliance. The administration plan would allow insurance companies to determine whether or not to cover experimental treatments. One company might cover liver transplants or bone marrow transplants or leukemia, while another company up the street might not. Health plans within an alliance should all play by the same rules to avoid different coverage for different enrollees within an alliance. Otherwise people like Penny Puhl will fall between the cracks.

Second, treatment decisions, treatment protocols must be consistent within an alliance. Insurance companies will have strong incentives to cut costs by cutting coverage. They will have strong incentives to hire the low cost laboratory. Health plans are very likely to interfere with doctors' treatment decisions by developing their own treatment protocols and by increased reliance on utilization review companies. To the extent the variation between insurance plans occurs, the result will be anti-consumer.

Third, the grievance procedure outlined in the Health Security Act needs fixing. It is possible that consumers with complaints could be trapped inside the insurance company's complaint system without timely recourse to a neutral party. We believe that the alliance should play a larger and earlier role in resolving disputes.

I would like to close by modifying the popular slogan of the week regarding crime control—three strikes and you are out. It can be modified to health care reform. Strike one, make participation and employer contribution voluntary. Strike two, pass the buck in defining benefits to an outside commission. Strike three, encourage catastrophic policies with the $3,000 deductible. Any one of these crucial mistakes will totally undermine health care reform and result in gaps in coverage and continuing suffering, lack of needed health care and financial barriers to care. Thank you.

Senator METZENBAUM. Thank you very much, Ms. Shearer, for a very well thought out statement.

[The prepared statement of Ms. Shearer follows:]

Prepared Statement of Gail Shearer

Consumers Union[1] appreciates the opportunity to present our views on the need for consumer protection in a reformed health care system. Members of this subcommittee have worked for health reform for many years; I don't think you need convincing about the fact that there truly is a health care crisis in this country. In conjunction with the Campaign for Health Security, we have recently released reports that show how the health care crisis affects people at both ends of the age spectrum—seniors and children. Despite Medicare coverage, seniors suffer in the health care system because they can't afford prescriptions or the high cost of long-term care. They have restricted choice of doctors when low Medicare reimbursement rates decrease doctors' willingness to accept them as patients. They are forced to use their limited funds to pay their hospital deductible and their 20 percent copayments. They are victimized by a private long-term care insurance market that puts the profits of the insurance companies above the needs policyholders.

America's children, and their parents, know there's a health care crisis. When 450,000 pregnant women have no health insurance, inadequate prenatal care—and low birth-weight babies with a variety of ailments—are inevitable. Insurance policies regularly exclude the all-important well-baby and well-child check-ups. They rarely cover immunizations such as measles shots that can prevent serious chronic illness. Pre-existing condition exclusions and outright denial of coverage often leave children with serious illnesses uninsured. Children in need of chronic care including rehabilitation, such as children with cerebral palsy or children recovering from brain tumors, too often find that their needs are unmet. As families struggle to work their way out of poverty, they often found that they lose their Medicaid eligibility and the health care that their children so desperately need.

The nation urgently needs health care reform. Only two bills—the Wellstone/McDermott single payer bill and the Clinton bill—meet consumers' health reform needs. We do not believe that so-called reform that is voluntary will come close to providing health care security for all. Nor do we believe that the nation will be able to pay the bill for health reform unless employers are required to make a substantial contribution toward the cost. Furthermore, legislation that counts you as insured if your family faces a $3000 deductible is not the type of reform that consumers need.

We believe that health care reform must offer:

—universal, quality health care with comprehensive benefits for all U.S. residents—regardless of age, income, employment status or health status;

—cost containment with a national health care budget and control over wasteful paperwork and procedures;

—fair-share financing with savings from cost containment as a central funding source and additional funding obtained on a fair and equitable basis;

—public accountability with the structure being shaped by consumers' interests, not insurance companies' or pharmaceutical companies' profitability, and with consumers well represented on all boards overseeing health care; and

—consumer choice giving consumers the freedom to choose where they will go for health care and who will provide it.

Clinton Health Care Bill: Five key Provisions to Preserve

Next I plan to outline Consumers Union's "Five/Five Plan"—our recommendations for five of the most important provisions of the Health Security Act that Congress should fight hard against special interests to preserve, and five provisions of the Health Security Act that must be fixed to better serve the needs of consumers. Attached to my written statement is Consumers Union's analysis "The Clinton Health Care Act: What Will It Mean for Consumers?" This analysis measures the Clinton bill against our five principles and both outlines what's good about the Clinton bill and recommends 25 ways to make the Clinton bill even better. The five most impor-

[1] Consumers Union is a nonprofit membership organization chartered in 1936 under the laws of the State of New York to provide consumers with information, education and counsel about goods, services, health, and personal finance; and to initiate and cooperate with individual and group efforts to maintain and enhance the quality of life for consumers. Consumers Union's income is solely derived from the sale of Consumer Reports, its other publications and from noncommercial contributions, grants and fees. In addition to reports on Consumers Union's own product testing, Consumer Reports with approximately 5 million paid circulation, regularly, carries articles on health, product safety, marketplace economics and legislative, judicial and regulatory actions which affect consumer welfare. Consumers union's publications carry no advertising and receive no commercial support.

tant elements to preserve—against the misguided ad campaigns and high-pressure tactics of special interest groups—are:

1. UNIVERSAL HEALTH CARE MUST BE A REALITY WITHIN THREE OR FOUR YEARS

Etending universal health coverage to all must NOT be dependent on achieving cost savings and must not be phased-in with a vague timetable. As long as insurance coverage is voluntary, there will continue to be horror stories of the suffering of families who are left out of the system—families will continue to face financial hardship of uncovered health bills,children will not get the health services they need, insurance companies will continue to game the system to find ways to select the best risks and leave people in need uncovered. Americans want universal care—this week's USA Today/CNN/Gall Poll found that 79 percent of respondents favor reform that provides guaranteed health care for everyone.

2. COST CONTAINMENT THROUGH LIMITS ON PUBLIC AND PRIVATE SPENDING MUST BE KEPT

Global budgets and premium caps to curb cost growth in both the public and private sector health spending are essential. The Clinton plan appropriately includes curbs on health care spending, and this protection should not be sacrificed to give the failed "free market" cost containment efforts yet another chance to drive up health care costs. Congress must guard against health care provider pressure to abandon the ban on balance billing and physician self-referral. These are two culprits that have contributed to today's high costs. In addition, we urge you to oppose granting antitrust exemptions for doctors, hospitals, and pharmaceutical companies. We oppose allowing, as the Act proposes, fee-for-service providers to collude in negotiating with alliances on the fee-for-service reimbursement schedule. This will create upward, rather than downward, pressure on costs.

3. EMPLOYERS MUST BE REQUIRED TO CONTRIBUTE TO THE COST OF THEIR EMPLOYEES' HEALTH CARE

Congress must resist the efforts to make an employer contribution toward their employees' premium voluntary (as would several alternative "reform" proposals). Private employers will pay premiums totaling $185 billion in 1994, approximately 20 percent of the nation's health care spending. Without a mandatory contribution, this figure is very likely to decrease as employers continue the trend of responding to high costs by cutting health care benefits (for employees and/or dependents). Shifting the entire premium to individuals (as does at least one reform bill), even with subsidization of the premium for the lowest income families, will put a very steep burden on many families and is likely to result in premiums being simply unaffordable by many families. Not only will this leave millions of people without insurance, but it will mean that their families—pregnant women, children with diabetes, fathers with high blood pressure, grandmothers with Alzheimers' disease—will be subject to pre-existing condition exclusions (typically for a period of six months) if they are able to afford health care coverage in the future.

4. KEEP THE BENEFITS PACKAGE COMPREHENSIVE

One of the strengths of the Clinton administration health care reform package is the comprehensiveness of the benefits package, including benefits such as prescription drugs, some long-term care benefits, doctor care, hospital care, and preventive care. The benefits package must not be whittled away, or else the concept of universal protection and security will be compromised, and a burgeoning supplemental market will develop and help perpetuate a multi-tiered health care system. And it is essential that the benefits package be explicitly defined in the bill. Congress should not pass the buck to a commission—and put consumers at risk of having less protection than they have today.

5. MAINTAIN THE STATE SINGLE PAYER OPTION

The Health Security Act provides states with the option to implement reform through a single payer system. We believe that the single payer option is the best option for states; states that opt for a single payer system will provide their residents with a system that is universal, contains costs, is fairly financed, is accountable to the public, and allows full consumer choice of provider. A December study by the Congressional Budget Office estimated that single payer—if adopted nationally—would cut total national health care expenditures by $114 billion in 2003. We

believe that a single payer system continues to provide the best value for consumers' health care dollars. It is critical that states have the single payer option.

Clinton Health Reform Bill: Five Provisions to Fix

While the Health Security Act makes a good start at providing consumers with health care security, it is far from perfect. The attached analysis outlines 25 changes that would improve the bill. In this statement I outline five of the most important consumer-friendly changes that Congress should make to the Clinton proposal.

1. PROTECT LOW- AND MIDDLE-INCOME CONSUMERS FROM FACING FINANCIAL BARRIERS TO CARE OR BURDENSOME PREMIUMS

The Clinton' proposal—with its premium subsidies and cost-sharing subsidies—goes a long way to reducing financial barriers to health care. An important feature of the legislation is the 3.9 percent of income limit (for families with income up to $40,000) that families must pay for their share of the premium. We believe that the limit should be lower, and recommend reducing this limit to 2 percent.

The legislation also provides premium discounts for families with income below 150 percent of poverty. Discounts cover the entire premium for the families below poverty, and are phased-out once the family income reaches 150 percent of poverty. Families in the income range of $5,000 to $20,000 could pay about 2.5 percent to 3.9 percent of their income on premiums, and possibly more if they choose a higher-than-average health plan.

While families receiving cash assistance (e. g., AFDC) face copayments of $2 per doctors visit and $1 prescription, the low cost-sharing plan includes $10/doctors' visit and $5 per prescription drug copayments for others, including many low-income families. This could present a financial barrier to care for many families. In addition, the bill's cap on funding available for low-income and other subsidies could threaten the availability of subsidies for low income consumers. The total estimated value of the low-income cost-sharing subsidies for 1994 through 2000 is $12 billion [Lewin]. We believe that low-income consumers need much greater protection from financial barriers to health care, both increased premium subsidies and increased cost-sharing subsidies.

2. INCREASE ACCOUNTABILITY TO CONSUMERS BY PROHIBITING INSURANCE COMPANIES FROM VARYING THE BENEFITS OFFERED WITHIN EACH ALLIANCE, BY SHIFTING THE APPEALS PROCESS OUTSIDE THE INSURANCE COMPANY, AND BY REDUCING THE ABILITY OF INSURANCE COMPANIES TO DENY COVERAGE

Health alliances serve several very important functions in the Health Security Act. Not only do they serve as a purchasing cooperative to negotiate premiums with health plans and to spread the risk among all participants, but they would provide comparative information to consumers to facilitate the selection of a health plan. We believe that the role of individual health plans should be decreased and the role of regional alliances should be expanded to serve these three functions: standardize health benefits, provide a unbiased appeals mechanism, and provide for fair determinations of the appropriateness of treatments.

Standardization of health benefits is one of the key principles underlying the entire Health Security Act. Yet, the plan would allow insurance companies to determine whether or not to cover various experimental treatments. One company might cover bone marrow transplants for leukemia, while another company up the street might not. Since consumers are allowed to change plans even in the middle of an enrollment year "for good cause," patients whose treatment is denied would be likely to switch plans. It makes far more sense for each health plan within an alliance to play by the same rules and avoid the disruption that would be caused by different coverage under different health plans.

In addition to uniform coverage (within an alliance) of experimental treatments, it is also important that treatment decisions be consistent within an alliance. To the extent treatment protocols are used, they should be developed at the alliance level, and not left in the hands of competing insurance companies. Insurance companies will have a strong incentive to cut costs by cutting coverage. Health plans are very likely to interfere with doctors' treatment decisions by developing their own treatment protocols and by increased reliance on utilization review companies. To the extent that variation between insurance plans occurs, the result will be anti-consumer. If competition among health plans is based on unhealthy competition that challenges insurance companies to develop protocols heavily weighted against needed medical treatment, consumers will be ill-served.

The Health Security Act allows health plans to create grievance systems that could prove burdensome for consumers. It is possible that consumers with complaints could be trapped inside the insurance company's complaint system without timely recourse to a neutral party within the alliance. Section 5202 establishes a complaint review office in the regional alliance, but explicitly requires that a complaint can not be filed with the alliance "until the complainant has exhausted all remedies provided under the plan with respect to the claim." This process could take many months—and many consumers with complaints will be gravely ill and simply will not be able to wait this long to resolve their problem. Again, the role of the alliance—as a neutral party—should be expanded to correct this problem.

3. MAKE FREEDOM-OF-CHOICE OF PROVIDER A REAL OPTION FOR PEOPLE OF ALL INCOME LEVELS BY REQUIRING ALL HEALTH ALLIANCES TO OFFER A FEE-FOR-SERVICE PLAN THAT COSTS LITTLE MORE THAN THE AVERAGE COST PLAN

Freedom to choose their health care provider is one of the most highly valued features that consumers seek in the health care system. Consumers want to be able to continue long-standing relationships with their family doctors, specialists, pediatricians, and other health care providers. Often, one family will have an array of doctors, making it impossible to follow them all to one HMO. Consumers want to be assured that if serious illness strikes, they will have access to the highest-quality specialist and specialized treatment centers.

We recommend that two changes be made in the Health Security Act in order to guarantee that freedom of choice of provider becomes a reality for consumers of all income levels. First, the plan should limit the difference in premium between fee-for-service plans ad the average premium plan so that low- and middle-income consumers can enjoy freedom-of-choice of health care providers. Second, it should require that alliances limit fee-for-service plans to one in order to achieve administrative costs savings ad avoid risk selection problems.

Premium differential. Under the Health Security Act, both employer premium contributions and premium subsidies are based on the average cost health plan. If a consumer selects a plan whose premium exceeds the average, the consumer is liable for the entire extra premium. We are concerned that this pricing structure could create a multi-tiered system In which the quality of one's health care will be dependent on income. We fear that many low- and middle-income consumers will not be able to afford to pay considerably higher premiums that are likely to be associated with fee-for-service plans. Without some constraint on premium differentials between fee-for-service and HMO-types of plans, freedom of choice of provider could be a luxury only the rich can afford. Health alliances should take steps to assure that competition among health plans is based primarily on quality, not price.

Number of fee-for-service plans. While an earlier draft of the Administration proposal would have given authority to regional alliances to limit the number of fee-for-service plans, the Health Security Act (section 1321) includes a very limited list of reasons under which regional alliances can refuse to allow health plans to offer fee-for-service plans (e.g., premiums that exceed 120 percent of the weighted average premium). We recommend that the regional alliance have a competitive bidding type of process to determine which carrier should administer the fee-for-service plan; the alliance could select the carrier that would provide the highest quality and the best value and service for consumers. We agree with the assessment of Paul Starr and Walter Zelma, key participants in the Administration's development of the plan, who concluded that limiting the fee-for-service option in this way is desirable because of anticipated savings in administrative costs and prevention of risk selection problems.[2]

4. INCLUDE THE BLUEPRINT FOR PHASING-IN NURSING HOME BENEFITS AND EXPANDED COMMUNITY CARE BENEFITS

The United States faces a growing long-term care crisis that will only get more severe as the population ages. Consumers Union has concluded that the private insurance market is incapable of solving the nation's long-term care problem—it will never cover people who can not afford the high premiums of private long-term care insurance, nor will it protect people whose pre-existing conditions make them uninsurable. The draft health plan includes an important community based care benefit. But the requirement that potential beneficiaries must be unable to perform three

[2] Paul Starr and Walter A. Zelman, "A Bridge to Compromise: Competition Under a Budget," Health Affairs (Managed Competition: Health Reform American Style?), Supplement 1993, p. 12–13.

"activities of dally living" limits the benefit to a small portion of people in need of long-term care. For example, a person incapable of moving around (e.g., from bed to a chair) and unable to go to the bathroom by herself can not be left alone all day long, but may not qualify for the new community-based benefit.

Consumers Union supports including in the health plan a blueprint for future expansion of public long-term care benefits, including both expanded community based care ad nursing home care. We recognize—as should the Congress—that these benefits will require a substantial new funding base, and we recommend that you consider increasing estate taxes (possibly by taxing capital gains at death), charging premiums for persons with incomes above a certain level, and increasing income taxes and possibly payroll taxes to pay for this additional important benefit.

5. GIVE THE NATIONAL HEALTH BOARD THE AUTHORITY TO REGULATE PRESCRIPTION DRUG PRICES THAT APPLY TO ALL AMERICANS

The Health Security Act has several provisions that will help to keep prescription drug prices in check. The National Health Board, for example, can make public declarations regarding the reasonableness of launch prices for new drugs and can study and report on the reasonableness of drug prices. In addition, rebates of at least 17 percent of the average manufacturer price are required for drugs issued through Medicare. We believe the plan needs to go further. The United States is the only industrialized country that makes no effort to regulate drug prices, forcing U.S. consumers to pay higher prices to help pay for research that benefits citizens of other countries, who pay much lower prices. The Office of Technology Assessment reported that during the 1980's, pharmaceutical companies on average earned about 15 to 30 percent more profit than was needed to attract adequate investment capital. Just this week, Senator Pryor released a report showing that in 1993—a year during which drug manufacturers' boast about relatively low price increases—drug price inflation was 15.5 times the overall ate of inflation. If drug prices were a river, they would already be well over flood stage—it is meaningless to talk about a voluntary price controls since prices are already so out of-line. We strongly recommend that the National Health Board's responsibilities include the authority to regulate prescription drug prices.

In sum, the popular slogan of the week regarding crime control, "three strikes and you're out" can be applied to health care reform.

—Strike one: make participation (and employer contribution) voluntary.

—Strike two: pass the buck on defining benefits to an outside commission;

—Strike three: encourage catastrophic policies with a $3,000 deductible.

Any one of these crucial mistakes will totally undermine health care reform, and result in gaps in coverage and continuing suffering. We urge you to avoid these mistakes and assure that consumers dream for universal, comprehensive health care benefits becomes a reality.

Thank you for the opportunity for Consumers Union to present our views on protecting consumers in health reform.

SUMMARY

There is indeed a health care crisis. Seniors face many health care problems, including:

—unaffordability of prescription drugs and long-term care;

—restricted choice of doctors when doctors refuse to accept Medicare payment levels; and

—burdensome cost-sharing.

Children face a health care crisis:

—8.3 million children have no insurance;

—450,000 pregnant women have no health insurance, and the lack of prenatal care can result in low birth-weight babies;

-insurance policies often exclude preventive care such as measles shots and check-ups; and

—families who work their way out of poverty lose their Medicaid coverage.

Health care reform should offer:

—universal, quality health care with comprehensive benefits;

—cost containment with a national health care budget;

—fair financing, with savings from cost containment and financing based on ability to pay;

—public accountability; and

-consumer choice of health care provider.

Congress should fight the special interests and preserve these crucial 5 provisions in the Health Security Act:

—universal health care must be a reality within 3 or 4 years;
—cost containment through limits on public and private spending must be kept;
—employers must be required to contribute to the cost of their employees' health care;
—the benefits package must be comprehensive; and
—the state single payer option must be maintained.

We recommend that Congress improve the act in the following ways:
—protect low- and middle-income consumers from facing financial barriers to care or burdensome premiums;
—increase accountability to consumers by prohibiting insurance companies from varying (or denying) the benefits and by improving the appeals process;
—make freedom-of-choice of provider a real option for people of all income levels;
—include the blueprint for phasing-in nursing home benefits and expanded community care benefits; and
-Give the National health Board the authority to regulate prescription drug prices that apply to all Americans.

"Three strikes and you're out" can be applied to health care reform.
—Strike one: make participation (and employer contribution) voluntary.
—Strike two: pass the buck on defining benefits to an outside commission.
—Strike three: encourage catastrophic policies with a $3,000 deductible.

Any one of these crucial mistakes will totally undermine health care reform, and result in gaps in coverage and continuing suffering.

Senator METZENBAUM. Geraldine Dallek.

Ms. DALLEK. Yes.

Senator METZENBAUM. What does MPH stand for?

Ms. DALLEK. Masters of Public Health.

Senator METZENBAUM. Speaking for the Center for Health Care Rights, on behalf of the Coalition for Consumer Protection and Quality. Is that for the Consumer Coalition in Los Angeles?

Ms. DALLEK. No, that is a national coalition, and there are 25 consumer groups that are part of the Coalition. And they have asked me to speak here today, in part because my program in the Center for Health Care Rights—we are a member of the Coalition and we deal and we have firsthand knowledge with what happens to beneficiaries enrolled in HMOs, particularly the Medicare population. My program was originally called the Medicare Advocacy Project. We recently changed our name.

Consumer protection is the foundation of health care reform and those of us from LA know how critical strong foundations are. I could not pass up reference to the earthquake. The Coalition applies the President's all out effort to reform the health care system. However, we believe additional consumer protections are badly needed.

One, we need stronger due process protections. Oftentimes people roll their eyes when they hear about due process protections. When I tell you, having dealt with thousands of Medicare beneficiaries enrolled in HMOs, 30 percent of the Medicare population in LA are in HMOs, due process, and appeal protections are absolutely critical. Specifically, the Coalition believes that the due process protections in the Clinton plan are a very good first step, but need to be strengthened.

We recommend that Congress clarify the circumstances for providing written notice to patients when a decision to deny, reduce, or terminate a service or payment has occurred. People have to be given a written notice that we are not going to be providing you this service and how you can appeal, if you are denied a service. Firmly, they must have an expedited review system in place that is outside of the plan. The tragedies that happened to Ms. Puhl and

Ms. Smith might well have been avoided if they had been able to go outside the plan and get expedited review of their conditions. Again, it has to be outside the plan. Clinton has it inside, but it must be in an independent, medical review group that would make a decision on yes, they are inappropriately denying you care. Due process protections are absolutely critical.

Second, we believe there needs to be establishment of an external, independent, and quality review entity. Researchers measure quality by looking at structure, process of care, and outcome of care. The report cards are not enough. Each method complements the other two and is necessary for a complete picture of the quality provided.

The Coalition believes that the Health Security Act should create external quality review entities that we call quality improvement foundations in each State, and that they should be independent of both the alliances and of the plans. The quality insurance foundations would perform quality, monitoring, and improvement functions such as development and support for quality improvement activities, analysis of plan utilization rates, and monitoring of plan compliance with practice protocols and provision of consumer information beyond the report card.

Last year my program did a study of Medicare risk contract HMOs in California and we collected some utilization data showing that one large HMO performed six times fewer heart bypass operations on Medicare beneficiaries than another HMO. We wanted to make sure this data was good data, we were told there were some problems with the reporting of the data. We went to HCFA and we said, look, there is a six-fold difference here, let us get better reporting data to see if this difference is real, and if it is, what is going on here with this HMO that provided almost no heart bypass surgery? Instead, HCFA said the data is lousy and said to the PROs do not bother any more with this data, because it is not good data. Just the wrong response. We need better data, not less data. We need a lot more data that our written testimony spells out in terms of protecting consumers.

Third, we need better consumer representation. Public accountability depends greatly on consumer representation on advisory boards. We request that you improve the consumer representation provisions of the Health Security Act to include a majority of consumer on all boards and for consumer training and support staff.

Fourth, and here is a point that you made earlier, Senator Metzenbaum, we need better State monitoring responsibilities. The Health Security Act gives States the authority to certify and monitor plans, but provides no guidance on either certification criteria or monitoring requirements. Most States do not currently have the expertise to protect consumers in a managed care environment. The history of Medicaid HMOs is replete with States' failure to adequately protect the low income population enrolled in HMOs. Studies by the GAO and others have found that States do not adequately monitor HMOs serving the privately insured population as well. And we have a lot of examples of that.

Fifth, we support the efforts of the Health Security Act to establish an ombudsman program, but we believe that it needs to have

an independent source of financing and that the ombudsman office must be independent of plans and alliances to protect them from conflict of interest.

And finally, I would like to talk a little bit about risk arrangements. We know very little about the relationship between the risk of individual providers to provide too little care and outcomes of care. I think we need to do a lot more work in this area. We should limit the amount of risk providers. We should look at who bears the risk, how much financial risk, and for what services. We should limit risk and we should also try and think about how to limit profit. In Los Angeles, there are 13 HMOs buying for the Medicare population in terms of enrollment. These HMOs are spending thousands and thousands of dollars on advertising and they are also making a great deal of profit off the Medicare population. And we need to somehow figure out how to make sure that profit is not made at the expense of the population.

I, and the Coalition, thank you for this opportunity to talk to you and we have a white paper we would like to submit for testimony.

Senator METZENBAUM. Your entire statements will all be included in the record.

[The prepared statement of Ms. Dallek follows:]

PREPARED STATEMENT OF GERALDINE DALLEK

Mr. Chairman, members of the committee, my name is Geraldine Dallek. I am the Executive Director of the Center for Health Care Rights (formerly the Medicare Advocacy Project). The Center for Health Care Rights (CHCR) is a Los Angeles-based independent non-profit organization dedicated to ensuring that consumers obtain the medical care services to which they are entitled. Today, I am representing the Coalition for Consumer Protection and Quality in Health Care Reform, a coalition of more than 25 consumer groups. We thank you for providing the Coalition with the opportunity to testify.

The Coalition asked me to represent it today because CHCR has first hand knowledge of the problems and barriers faced by managed care enrollees. Through its state HICAP grant, CHCR provides direct counseling and legal assistance to over 5,000 Medicare beneficiaries annually. In 1993, the Center released the results of a year long study of Medicare HMOs.

The Coalition applauds the President's all-out effort to reform the health care system. Specifically, we are pleased with the attention to consumer empowerment through an extensive system of data collection, analysis and dissemination. The administration has also demonstrated its concern for patients rights through the establishment of an ombudsman program and appeals/grievance procedures.

However, it is the Coalition's assessment that additional consumer protections are needed to ensure that managed care plans provide high quality care. The linchpin of any national health care reform system is consumer satisfaction. Managed competition can work, but only with very strong consumer protections to ensure that plans do not contain costs by providing less care.

Many managed care advocates believe that providing managed care enrollees with cost and quality information (through a report card) is enough to protect consumers and to force plans to provide high quality care. They believe that buyers of health care (consumers) unhappy with a particular plan can simply "vote with their feet," by changing plans. Unfortunately, experience with managed care plans shows that this ideal bears little resemblance to the real world of managed care.

Today, I would like to address four areas of particular interest to consumers:

—Due Process Protections
—Information Needed by Consumers
—An Independent Ombudsman Program
—Quality Improvement and Public Accountability

Each of these areas is addressed separately below.

I. Consumer Due Process Protections

BACKGROUND

The Coalition believes that consumer notice, appeal, and grievance rights—collectively referred to as consumer "due process tights"—are essential in any nation health care plan. Under a managed care system, health plans and their utilization review systems work to keep the cost of care down. In some instances this will be done at the expense of the medical needs of enrollees. Therefore, access to an independent and timely appeals process is critical to maintaining quality care for consumers.

Medicare beneficiaries enrolled in HMOs do have some, although inadequate, due process protections. The working population enrolled in managed care plans has even fewer protections.

Currently, Medicare HMO enrollees have little protection when a needed service is denied, delayed or terminated. Often they are unaware of their appeal rights. And if they do appeal, the appeals system takes months and often even years.

Numerous studies have found that managed care plans can and do provide high quality cue to enrollees. Other studies, however, raise serious concerns about the incentives inherent in these plans to underserve enrollees. To counter these incentives, the Health Security Act needs stronger consumer due process protections, as the following case illustrates:

—Mrs. S is a 73-year-old Medicare beneficiary suffering from chronic pulmonary disease (a lung disorder). Mrs. S. lives in Los Angeles and, like one-third of the Medicare population in the County, belongs to a Medicare risk-contract HMO. In December 1993, while visiting relatives in San Diego, she was hospitalized as an emergency patient and placed on a ventilator to help her breathe. Her attending physician felt strongly that if she was discharged to a rehabilitation hospital for acute respiratory therapy, she could be weaned from the ventilator and return home. The attending physician also believed that if she was not weaned, she would die.

—The HMO refused to approve the transfer, instead offering to discharge Mrs. S. to a less costly nursing home, which could not wean her from the ventilator. Ms. S.'s family sought help from the Center for Health Care Rights. After two frustrating days of attempting to work with the HMO on Ms. 5's behalf, the HMO acknowledged the need to wean Mrs. S. but still did not authorize rehabilitation care. It was only after the Center's Director of Litigation advised the HMO's officers that she would be appearing in court the following morning to obtain a temporary restraining order that the HMO approved Ms. 5.'s the transfer to the rehabilitation hospital.

Although the Center was finally able to help Mrs. S. obtain appropriate care, without the Center's intervention, she might well have been transferred to a nursing home, where she would have remained while her appeal slowly made its way through the system.

Recommendations—A. Appeals Process

The Coalition is quite pleased with many of the review processes envisioned by the Health Security Act. The Act's basic approach is consistent with our White Paper, which we request be inserted in the record. We have, however, several concerns about lack of an adequate notice of appeal rights, lack of an expedited review process, the length of the appeals process, and the lack of plan payment for second opinions.

1. Notice of Appeal Rights

Congress should clarify the circumstances for providing notice to patients when decisions to deny, reduce, or terminate a service or payment has occurred. Specifically, the Coalition recommends that notice provisions of the Act be strengthened to include the following:

—Notices should be triggered automatically when certain benefits, such as hospital, in-patient rehabilitation, nursing home and home health care, have been denied, reduced or terminated;

—Notices should state the specific reasons for the decision and describe the appeals process available to the patient; and

—All plans should be required to provide enrollees with periodic notices of their appeal rights and prominently place notices describing appeal rights in provider waiting rooms.

In addition, the Health Security Act should clarify that what the Act refers to as a "claim" includes the review of a decision to terminate services.

2. Need for Independent Expedited Review

CHCR's study of Medicare HMOs and extensive experience with clients leads us to conclude that without an expedited review system an appeals system is useless in cases of under service. The appeals system takes months at a minimum. Often managed care enrollees denied needed care do not have months to wait for service. Even short delays in the provision of services, such as home health care, rehabilitation services, MRIs, specialty care and surgeries can have harmful and permanent effects. The Health Security Act does call for an expedited review system, but one that is not independent of the managed care plans. The Coalition strongly recommends the following additions to the appeals process:

—All managed care enrollees should have available to them an expedited appeals system operating independently of the managed care plans for denials/delays in treatment that could seriously jeopardize their health or well being. (PRO review of contested hospital discharges of Medicare patients is an example of how an expedited review system might work.)

—The independent monitoring organization should render a decision on all expedited reviews within 24 hours.

3. Shortening of Appeal Time Period

The Clinton plan gives plans 30 days to make a decision of an initial appeal and an additional 30 days to make a second decision on a request for reconsideration. The Health Security Act also requires that all claimants must first go through the initial and reconsideration stages prior to referral to a state Complaint Review Office. The Coalition believes that Congress should consider the following options to shorten the appeal process:

—The reconsideration state of the appeal process should be eliminated, allowing enrollees to directly appeal to the Complaint Review Office following a plan denial of the initial appeal; or

—The time allowed plans to make initial and reconsideration decisions should be shortened to 15 days each.

4. Plan Coverage of Second Opinion

The Clinton bill places the responsibility and costs of purchasing second opinions on the beneficiary. This places an unacceptable burden on the beneficiary. For low-income individuals in particular, this burden will negate the appeal right. In response to this problem, the Coalition recommends that:

—The Health Security Act should require plans to pay second opinions for specified conditions/procedures.

5. Point-of-Service Option

The provision of additional information is not enough to protect HMO enrollees in enrolled in plans that provider poor quality of care. The Health Security Act permits consumers to switch plans only once a year. Therefore, it is critical that managed care enrollees retain the option of seeking care outside a managed care plan. Specifically, the CHCR strongly recommends that:

—The Health Security Act's requirement that HMOs offer a "point-of-service option" be retained.

B. Grievance Process

Each alliance should assure that its certified plans initiate and maintain a grievance process for patient complaints about problems other than denial, reduction, or termination of service or payment. The grievance process should contain the following components:

—Oral and written complaints from patients should be investigated by a patient advocate, who will prepare a written report for the plan and the consumer within 15 days;

—The plan's or insurer's grievance committee should issue a decision within 30 days regarding the patient advocate's report. The written decision should be sent to the grievant;

—Statistics on number and outcome of grievances by plan should be public; and

—Grievants dissatisfied with the grievance committee action should be able to obtain a review by the Complaint Review Office.

The Coalition's White Paper contains a number of additional recommendations on the appeals process and grievance procedure.

II. Consumer Information—Background

Currently, health care consumers lack even the most basic information about the quality of care provided by managed care plans. The most common question asked by Medicare beneficiaries considering whether to join an HMO is "which one is best." Unfortunately, we have no answer to this question and Medicare beneficiaries are forced to make their health care choice in a complete information vacuum.

Moreover, the little consumer information that is collected is of dubious quality. The Health Care Financing Administration (HCFA) and state governments have been extremely lax about HMO data collection in both the Medicare and Medicaid programs. HCFA, for example, collects, but does not analyze Medicare HMO disenrollment data, collects no meaningful utilization or outcome data by plan, and has very loose standards for defining (much less investigating or keeping data regarding) types of complaints received. In short, HCFA collects and provides to the public no usable quality of care data.

California's PRO reports that some HMOs serving the Medicare population cannot even provide the most basic information, such as which enrollees have signed up with which subcontracting medical groups. Thus, the HMOs are unable to provide CMRI with the patient records needed for its HCFA mandated quality review functions.

Further, with few exceptions, state and federal governments and most HMOs are unwilling to provide consumers and their representatives with any quality of care information.

Recommendations—A. Information

The report card data required in the Clinton plan is an excellent first step toward ensuring that health care consumers have the quality of care information needed to make an informed decision. However, the Coalition believes that additional comparative, plan-specific and condition-specific information should be provided to consumers. The list below is only suggestive of the types of information we believe consumers need. For additional suggestions, I refer you to the Coalition's White Paper submitted for the record.

1. Comparative Information

Congress should require the collection and yearly publication of a number of addition comparative quality of care measures, including:

—Results of consumer satisfaction surveys;

—Plan enrollment and disenrollment figures;

—The ratio of complaints/grievances and appeals to plan enrollees;

—Information on plan providers and costs of out-of-plan use;

—Ratio of primary care practitioners to enrollees and the ratio of board certified to non-board certified physicians;

—Information on plan benefits and any limitations on these benefits;

—Individual plan risk-arrangements (financial incentives under which plan health care providers operate); and

—Plan utilization data for selected services, including hospitalization, home health visits, and psychiatric visits adjusted for age, sex and, when possible, health status.

2. Plan-Specific Information

Plans or health alliances should provide all enrollees with the following information primary care physician and other plan providers:

—Fact sheets on plan physicians—their training, years of practice, board certification, faculty responsibilities, and confirmed disciplinary actions such as repeated malpractice payments; and

—On request, fact sheets on individual hospitals, home health agencies, laboratories, pharmacies and other contracting providers including a list of services and other details.

3. Condition-Specific Information

Plans should be required to provide age, sex and, when feasible, severity adjusted condition- or treatment-specific information and a comparison with similar information for the region, state or nation. For a particular condition/surgery, this data could include:

—Number of surgeries performed (by hospital and by surgeon);

—Death rates within a specified time period;

—Complication rates for specified surgeries (e.g., surgery for prostate cancer); and

Hospital infection rates (generally) and readmissions for the same condition within a specified time period.

To ensure a better protected and informed public and to promote national consistency in data reporting, the Coalition believes that Congress should add greater specificity to the types of consumer information which must be made available.

B. Plan Marketing Controls

The Health Security Act requires alliances to approve all plan marketing materials. The history of both Medicare and Medicaid HMOs provides ample evidence that HMO marketing activities are open to serious abuse.

Consumer report cards with outcome and other measures of data is critical if consumers are to make informed decisions on which health plan to join. However, if alliance controls on marketing are not adequate, plan marketing activities (including television, radio and print advertisements, celebrity spokespersons, and the actions of individual marketing agents) could undermine the report cards' effectiveness. At a minimum, the Coalition believes that marketing by managed care plans be carefully scrutinized. I personally support the following limitations on plan marketing:

—The percentage of plan revenues that can be spent on marketing should be limited;

—All plan marketing materials should be required to contain specified report card information; and

—Door-to-door and in-home marketing should be prohibited.

III. Ombudsman Program—Background

The Coalition is pleased that the Health Security Act calls for the creation of ombudsman offices to assist consumers with their questions and concerns and to serve as consumer advocates, helping consumers negotiate the system and resolve complaints.

The Coalition believes, however, that the Health Security Act should provide much greater specificity regarding how this program will be designed and how it can be used by consumers. We also believe that, to be truly effective, the program must be adequately financed and operate independently of the alliances.

Models for such programs can be found in the State Long-Term Care Ombudsman Program mandated by the Older Americans Act and California's Health Insurance Counseling and Advocacy Program (HICAP), which provides education, counseling and legal assistance to Medicare beneficiaries. The Center for Health Care Rights is a HICAP grantee.

Recommendations—A. Financing

The Health Security Act includes the option for alliance eligible individuals to designate one dollar of their premium toward an ombudsman program. This approach puts the program in jeopardy from the beginning. Not every enrollee will understand the value of the program until they have a problem and need its services. Further, for the ombudsman program to be effective, it needs a trained, full-time staff supported with a steady year-to-year appropriation. To ensure an effective ombudsman program, the Coalition recommends that:

—The Act should mandate that a percentage of premiums collected be set aside to cover the costs of the Ombudsman program and other quality improvement and consumer protection systems.

B. Independence

The Health Security Act locates the ombudsman offices in the alliances. We believe that this creates a conflict of interest. The ombudsperson must assist with both plan and alliance-related problems. It is unrealistic to expect the ombudsperson to effectively deal with problems that arise within the alliance if it is located in the alliance and receives funding from it. To ensure an effective consumer advocacy Ombudsman program, the Coalition recommends that:

—The Ombudsman program be established as a non-profit consumer organization totally separate and independent from the alliances.

IV. Quality Improvement and Public Accountability—Background

The Consumer Coalition believes that consumer information, consumer protection, and quality improvement programs must be accountable to the public, independent of providers and payers of health care, and free of potential conflicts of interest.

The Health Security Act provides an excellent foundation for independent monitoring of quality through the establishment and functions of the National Health Board, National Quality Management Program, and the National Quality Management Council at the federal level and the alliance quality of care reporting requirements at the state and local level.

Quality of health care is measured in three ways: structure, process; and outcome. All three complement each other and are needed if we are to adequately protect consumers in any managed care plan.

The Clinton plan does provide for information on outcome measures. However, the Clinton plan does not include the establishment of consumer-based independent entities to monitor and improve the quality of care provided by plans.

Nor does the plan ensure public accountability and adequately define the role of states in ensuring that consumers are protected through strong licensing and certification and enforcement of quality protections.

Recommendations—A. Quality Improvement Foundations

The Clinton proposal should include an external quality review entity, independent of the payer-based alliances and provider-based plans to monitor and improve quality in each state. For purpose of reference, we call these entities "Quality Improvement Foundations" or QIFs.

The National Quality Management Council would provide competitive grants to create one QIF in each state. The QIF would be governed by a consumer majority with representation of experts in a variety of health and quality research fields.

Each QIF would perform a variety of quality monitoring and improvement functions, including:

—Performance of expedited quality of care reviews;
—Data analysis and data quality testing;
—Dissemination of information on successful quality improvement programs;
—Technical assistance to plans and alliances;
—Development of and support for quality improvement activities;
—Provision of consumer information beyond the report card;
—Monitoring and feedback to plans on adherence to practice guidelines;
—Analysis of plan utilization measures; and
—Quality assurance by providing:
——information to consumers
——feedback to licensing, certification, and accrediting entities and the National Quality Management Council for appropriate sanctions.

B. Medicare Quality Oversight

The Health Security Act proposes the termination of the Medicare Peer Review Organizations. Although the Coalition believes that the functions of these organizations could be strengthened, we oppose their elimination.

Under the Clinton proposal, states have the option of "integrating Medicare" into the Alliance system. Most states will likely keep Medicare separate initially, until they can assess how well the new program is working. If Medicare remains separate, it will not be covered by the quality protections in the Health Security Act. It makes no sense to eliminate PROs without a new program to monitor Medicare quality of care. We need stronger quality of care protections for Medicare beneficiaries, especially those enrolled in HMOs, not to wipe out what we have and start all over again.

C. Consumer Representation

One of the most effective ways to ensure public accountability is to mandate consumer representation on advisory boards. The Coalition is pleased that the Health Security Act recognizes the importance of consumer involvement by providing for consumer representation on some of the boards and advisory councils specified in the bill. However, we believe that the consumer role in the governance of the health care system must be strengthened. Consumers are in a unique position to advocate for a system that delivers high quality care—unlike payers or providers of care, they are immediately affected by any changes in the quality of care delivered and are free from potential conflicts of interest.

The Coalition recommends a stronger consumer role in the Health Security Act, including:

—Consumer control of the boards of regional health alliances and corporate alliances (the Act currently provides for no consumer representation on corporate alliances);
—Required consumer representation on the National Quality Management Council and the National Long-Term Care Insurance Advisory Council and other boards and commissions established by the Act; and
—Funds to train and provide technical assistance to consumer representatives.

D. STATE ROLE AND LICENSING, CERTIFICATION AND ENFORCEMENT

One area of quality assurance which the Coalition is currently analyzing is improving the effectiveness of licensing, certification, and accreditation entities.

The Health Security Act and its implementing regulations should include provisions for strengthening the federal and state roles in licensing and certifications, including:

—Setting of national standards on minimum requirements for certification of health care plans;

—Sufficient financial support for licensing and certification entities; and

—A range of sanctions to enable states to respond appropriately when plans do not adequately protect consumers.

CONCLUSION

Senators, the Coalition believes that proponents of the status quo in our health care system will distort the facts and attempt to scare consumers into believing that quality will suffer under the Health Security Act. We believe the improvements that we are recommending will protect quality further and provide consumers with the information, due process rights, quality improvement, and public accountability that will make this reform better for American consumers of health care.

The Coalition and CHCR are grateful to the Committee for holding this hearing and focusing its attention on these critical issues. We look forward to working with you during the year on these and other critical consumer issues of national health care reform.

Senator METZENBAUM. Mr. Lyons, we are very happy to see you again, sir. You and I have worked together before. The Commissioner of Insurance of the State of Iowa, and we are happy to have the point of view of the National Association of Insurance Commissioners?

Mr. LYONS. Senator, it is a pleasure to be here again and as Chairman of this committee. My name is David Lyons. As you have noted, I am the Vice President of the National Association of Insurance Commissioners and Commissioner of Insurance for the State of Iowa.

Mr. Chairman, I applaud your efforts to shine the spotlight on one of the most vital elements of health reform in this debate, and that is, consumer protection. Consumer protection goes to the core of what each and every State insurance regulator must do day in and day out. Our record is not flawless. That we freely admit and I have admitted that before in other areas. However, we have active meaningful reforms in which we take pride. Looking to the future, we are taking steps to further improve our efforts.

As for the current debate, we have put forth a check list that stands as what we hope as a measuring stick for any health reform plan. Rather than reinvent the wheel when it comes to protecting consumers under health reform, we should instead build upon the strong foundation that already exists in the States. For decades the States have been leading the charge with innovative and successful reform measures.

To cite but a few examples, the NAIC has enacted important small group insurance reforms which 45 States have adopted in just the last 2 years. The NAIC developed and the States implemented 10 standard Medicare supplement plans to assist consumers of that product, as has been referred to earlier. And we have taken steps that we can protect consumers. Hopefully, we can take steps to protect consumers covered by self insurance plans. We have gone as far as we can.

But it is crystal clear, however, that consumers will remain at risk, a significant amount of consumers, as long as the specter of ERISA hangs over the health insurance marketplace. The States can only regulate about 25 percent of Americans' insurance. Three consumers this morning on your panel noted the problems they had had. But if all three of those consumers had come to my agency, I as the State insurance regulator, would only have been able to assist one.

Senator METZENBAUM. Why is that?

Mr. LYONS. From the testimony, it appeared that one of them would have been an ERISA style situation where an employer was self-insured. I am forbidden from taking any action relating to self insurance by Federal preemption. And the other is a Medicare and a Medicaid issue. Again, another 25 to 30 percent of the spending on the Federal level.

Mr. Chairman, in our eyes, one of the most important things that you and this body could do is to sponsor and enact a bill to amend ERISA. It is clear that without consumer protection and the issue of ERISA reform, we will not have comprehensive health care reform. In the interest of consumers across the States and across this Nation, we plead with you unshackle our hands to begin regulating in the self-insurance area. Let us do our job and let us protect consumers in our State.

Turning to the road ahead, there are even more innovative health reform efforts now under development by the NAIC. We have turned our attention to risk based capital, standards for health providers, such as HMOs, Blue Cross plans, and others. That responds to the concerns that you and the Judiciary Committee have raised relating to the ability to monitor financial stability of health insurance companies.

And in addition, we are in the process of developing a health care purchasing alliance model act. The alliance model would allow small businesses to obtain health insurance coverage for their employees through State chartered pools, be they mandatory or voluntary. In addition, we are moving forward with initiatives on standardized claim forms, experimental treatments, and 24-hour coverage—all issues which you have expressed an interest in, and a dozen other important initiatives.

There are several items we have identified that must be in any part of a reform plan. Our check list is designed to ensure that consumers will come first when reform takes hold. This list includes at a minimum ERISA reform, flexibility for the States in implementing reforms, a clear process for providing assistance to consumers, a licensing agency, assurance that plans and policies offered comply with the law and with standard benefit requirements, the ability to prevent, detect and prosecute fraud, the confidentiality of medical data, and fair treatment for consumers and fair conduct by insurers.

Our long experience tells us these things are important to consumers. After all, we are close to them. They are in our State capitals. They are in our States. They are in my office every day. We are very close to consumers and these are the issues that they want addressed.

If I had the time and opportunity to respond to other testimony today and the problems which have been noted on managed care, I would outline the eight-part project the NAIC has on quality and accountability standards that would respond both to Geraldine's point relating to there being clear ability for the States to regulate in this area and responding to the concerns this morning of the inability to have consumer protection in the managed care environment. Perhaps that will come up in your questions and I can go into more detail.

But, Mr. Chairman, the tradition of health reform in the States runs broad and deep. State insurance regulators will continue to play an important role in assuring that consumers come first under health reform. Thank you, and I would be pleased to answer any questions you have.

Senator METZENBAUM. Thank you.

[The prepared statement of Mr. Lyons follows:]

PREPARED STATEMENT OF DAVID J. LYONS

Mr. Chairman and members of the subcommittee, my name is David J. Lyons. I am the Vice President of the National Association of Insurance Commissioners NAIC), and the Commissioner of Insurance of the State of Iowa.

The NAIC is the nation's oldest association of state public officials, composed of the chief insurance regulators of the fifty states, the District of Columbia, and four U.S. territories. On behalf of the NAIC, I want to thank you for the opportunity to appear before the Subcommittee on Labor to discuss the issue of consumer protection in the context of health care reform.

First, I wish to commend this subcommittee, the Congress, and the White House for moving health care reform to the top of the domestic agenda. For years, the NAIC has appeared before Congress to discuss various issues related to health insurance. We have explained that the best efforts of state insurance regulators to improve the nation's health care system could do only so much without broader reforms by the Congress and throughout the health care delivery and financing systems.

Second, I would like to express particular gratitude to you, Mr. Chairman, for focusing this hearing on the primary concern of state insurance regulators: consumer protection. The central mission of state insurance regulators is the protection of consumers, both from improper marketing practices and from the problems associated with insurer insolvencies. This mission will continue throughout the coming years in which we can expect to see a changing health care environment, and we appreciate this opportunity to provide this body with the benefit of our experience and expertise at this critical juncture, as the reform is being crafted.

Today I will address the full range of consumer protection issues involved in health care reform market issues, solvency, and consumer information. I will discuss how, in all three areas, states have done a good job protecting health insurance consumers. We would be the first to admit that our record is not flawless. However, we have done much, and continue to improve our efforts. As you will hear, significant reforms in the small group market have been enacted across the nation. Furthermore, as I will discuss later, seven states have adopted laws establishing purchasing cooperatives, or alliances, to help small employers and others band together to purchase health insurance.

I will also explain how the efforts of the states have been limited by the Employee Retirement Income Security Act (ERISA), which removes the regulation of the health insurance provided to many Americans from the reach of the states. Whether or not the current efforts to enact federal health care reform come to fruition, the Congress should at. least amend ERISA to correct the more serious problems created by that act. In addition, many state-based reforms require waivers from the confines of ERISA to implement new programs.

In any form of health reform—either the ongoing efforts in the states or other efforts currently being contemplated at the federal level—the creation of new risk-bearing entities carries with it the danger that requirements for the sound regulation of such entities will be overlooked. The NAIC has identified key consumer protection issues that should be considered by any government—state or federal—that is undertaking the formidable task of health insurance reform.

Under each of the three major issues (market conduct, solvency, and consumer information), I will address the past and present work of state regulators and the NAIC, the problems caused by, and the needed reforms in, ERISA, and our recommendations for insurance reform.

MARKET ISSUES: ACCESS, UNDERWRITING, AND PRODUCT QUALITY

Actions by State Regulators and the NAIC

SMALL GROUP MARKET REFORM

The NAIC has long recognized that, while the soaring cost of health care is a chief barrier to access to health care, it is not the only barrier. Indeed, rating and underwriting practices in the health insurance marketplace are also contributing to problems of access. That recognition has caused the states, both separately and together through the NAIC, to take an active role in the reform of these practices in the small group health insurance market.

In response to an increasingly price-competitive market, insurers have tried to gain a competitive advantage through risk selection and aggressive rating practices. As a result of these insurer practices, businesses with poor health or claims history must pay escalated rates for coverage, if they can get coverage at all. Furthermore, even small businesses with lower rates have no guarantee that they will remain low, and they face premium increases or a constriction or loss of coverage in the event an employee becomes ill.

State insurance regulators decided several years ago that, while we could not single-handedly solve all problems of access to health care, we could do something about these practices in the small group insurance marketplace. In December 1990, the NAIC took the first step by adopting a model law to protect consumers from rating abuses and renewability problems. The NAIC then built upon that initial effort by adopting, in December 1991, two alternative approaches to a comprehensive model act to reform the small group marketplace. While these alternatives provide for different mechanisms to achieve reform, both proposals:

—provide that a small employer may not be denied access to health insurance coverage because of the health status or claims history of employees and their families;

—provide for continuity and portability of coverage (by prohibiting application of pre-existing condition limitations) for insured small businesses changing carriers and for insured employees changing jobs;

—address abusive rating practices by limiting the use of claims experience, health status, and duration of coverage as factors in determining premium rates and annual rate increases for small employers;

—restrict cancellation or nonrenewal of coverage provided to small employers;

—require disclosure to purchasers of rating strategies and renewal rating factors;

—require insurers to file an actuarial certification and maintain certain resources to monitor compliance; and

—establish market conduct rules to assure that insurers make coverage broadly available.

It should be noted that 45 states have adopted some form of small group market reform. Most of these states have modeled their reform laws on the NAIC's model laws (see Attachment A, detailing small group reforms in the states).

Despite limitations on the impact of state market reforms that I will discuss in a moment, the reforms are providing substantial benefits to consumers. They offer the opportunity to induce the private payer industry to move away from the risk avoidance strategies that hurt consumers and businesses and to lead it toward risk and cost management strategies. Also, small group reform provides greater market and product stability, product availability, price predictability, portability, guaranteed renewability, and reduced inequities in the market.

There is one other, often overlooked, benefit to small group reforms—they can ease the transition to community rating for those states that are moving toward a community rating system. The implementation of community rating does not necessarily result in lower insurance rates. In fact, a sudden shift from a pre-reform market to a community rating market could create, at least in some states in which the insurance industry is typified by aggressive rating and underwriting, large dislocations in the market and large price shocks to insurance consumers. Reforms similar to the NAIC's small group market reforms deserve serious consideration as a vehicle for states to make a transition to a system of community rating in a less disruptive fashion.

Regulatory Framework and Health Reform

To help bring regulatory consistency to the fluid health care environment, the NAIC's Regulatory Framework Working Group is working to develop the Health Care Purchasing Alliance Model Act (Alliance Model). This is an effort at developing a more uniform and consistent approach for states to adopting alliance structures as part of health reform schemes.

The purpose of the Alliance Model is to enable alliances to improve the fairness, efficiency and competition in the pricing and delivering of health care and health care coverage for those consumers or dependents who work for small employers or who are self-employed. The Alliance Model seeks to achieve these goals through the creation of statewide and/or alliance supervisory boards, health plan qualification standards, marketing and reporting guidelines, and other insurance reforms necessary to increase coverage, affordability, and accessibility.

In addition, the Working Group is examining seven state alliance programs that were adopted or implemented in 1993 (California, Florida, Iowa, North Carolina, Ohio, Texas, and Washington) and is attempting to incorporate the best elements of each initiative into the Alliance Model.

The NAIC ultimately will develop two alternative models, a Voluntary Alliance Model and a Mandatory Alliance Model. Naturally, the mandatory model contemplates that a state would obtain the necessary waiver from the provisions of ERISA that would otherwise prohibit such state initiatives or that Congress has passed legislation that am' ends ERISA to permit or mandate such a structure (and the President signed it into law). The Working Group will focus on the Voluntary Alliance Model during the next several months and likely will complete this model by June 1994. The Mandatory Alliance Model should be ready by December 1994.

Quality and Accountability Standards

Of significant concern to NAIC members is the need to maintain quality and accountability in the regulation of risk-bearing health care organizations. To address that concern, an NAIC working group is developing eight model standards and/or guidelines for health plans and related organizations. The primary goal of the working group is to create standards that will help level the regulatory playing field for health plans and increase consumer protections.

The working group has established a panel, with participation from consumer representatives and federal and state regulators, to work on each of the following issues: quality assurance, utilization management, grievance procedures, credentialing, provider contracting, confidentiality, data reporting, and accessibility standards. The working group will complete these standards on a staggered basis; some will be finished as early as June 1994. The working group should wrap up its work by March 1995. The NAIC anticipates that the adoption of the working group's models would contribute to more uniform standards and, therefore, more uniform consumer protection.

For example, if a state adopted the group's model grievance procedures standard, all consumers in the state would be protected by the model's hearing and appeals process, regardless of the type of insurance carrier that provided their health care coverage.

In addition, the NAIC's State and Federal Health Insurance Legislative Policy Task Force is considering developing a model health care plan act that would govern many types of payers and plans, including health maintenance organizations, preferred provider organizations, point-of-service plans, fee-for-service plans, Blue Cross and Blue Shield plans, commercial indemnity plans, and other related organizations. Such a uniform model licensing act would protect consumers by ensuring that all companies that function like managed care organizations or insurers, such as newly formed provider-hospital organizations (PHOs), are properly regulated under a more cohesive and equitable system.

Standardized Claim Forms

If you ask consumers, health care providers, insurers, or anyone else with regular contact with the current health system to enumerate the major problems with the current system, nearly everybody's list would include the inscrutable and massive amounts of paperwork involved in getting health claims paid. To address this problem, the NAIC is developing a Standardized Health Claim Form Model Regulation. This includes a provision mandating that insurers and providers use electronic data interchange (EDI) for claims processing. It is our aim, through these steps, to ease the paper burden on consumers, providers, and insurers alike. We expect the NAIC to adopt this model regulation later this year.

Medicare Supplement Reforms

Over the last couple of years, the NAIC has designed and the states have implemented simplified, standardized benefit packages for Medicare supplement insurance. As a result, purchasers of that product no longer face the dizzying array of benefit packages that typified that market only a couple of years ago. With these standardized packages, consumers can now compare one policy to another and shop for the most appropriate benefits and the best deal, something that was very difficult or even impossible until the states took this step.

ERISA and Market Conduct: Limitations and Needed Reforms

ERISA's limits on market reforms

Certainly, the states' market reforms are limited, in part because of the burdensome confines of ERISA. States cannot do anything about the largest part of the health care financing market—that provided by large employers. In recent years we have seen the large-employer market mimic the small group insurers' past attempts to control costs and avoid risks through such vehicles as long pre-existing condition waiting periods, longer qualifying periods, changes in benefits, and exemptions for employee's dependents, to name but a few. State-level reforms currently cannot reach the problems raised by these trends in the large employer market.

Further, states cannot require self-funded ERISA plans to participate in state risk pools for uninsurables or in other risk-sharing mechanisms. In addition, they cannot require an employer to provide insurance, assess or tax self-funded ERISA plans, establish a minimum level of benefits for all citizens, or regulate any of the business practices or conduct of self-funded ERISA plans.

Let me tell you a story from a state insurance department's records which will better illustrate the ways in which ERISA impairs product quality.

In 1984, a three-year-old girl in Wisconsin nearly drowned in a lake next to her home. She suffered extensive brain damage and was left a non-communicative, spastic quadriplegic, requiring 24-hour care. Her airways must be suctioned frequently to prevent blockage, and she is fed through & gastrostomy tube that requires regular monitoring and maintenance.

The little girl was covered by her mother's employer's self-funded health plan. The plan initially paid for her daughter's in-home nursing care. After several years the health plan told the parents that their daughter's in-home benefits had been exhausted. The parents complained to the Wisconsin Office of the Commissioner of Insurance, but the department was unable to help because ERISA assigns exclusive jurisdiction over employer self-funded health plans to the U.S. Department of Labor. The family filed suit in state court and obtained an injunction that required the plan to continue paying for the care.

After the state court injunction, the employer amended the plan in such a way as to make indisputable that the girl's in-home nursing care coverage was terminated, then used ERISA as a justification for transferring the Case to federal court. There, the plan claimed that ERISA allowed the plan to terminate the youngster's eligibility. The federal court agreed, and dissolved the state court injunction. Since then, the public, through Medicaid, has paid for the young girl's care to the tune of about $1,000 per day, or over $1.5 million.

This story illustrates but some of the problems caused by ERISA. Some problems that state regulators have had with ERISA include:

—ERISA does not require self-funded health plan administrators to submit plan disclosure documents to any administrative agency for review;

—ERISA allows the plan administrator of a self-funded health plan to delay distribution of a summary of material modifications to the plan for up to 210 days after the end of the plan year in which the changes are adopted;

—ERISA prohibits consumers from bringing suit in state court alleging common law fraud and negligent misrepresentation about coverage under & health plan governed by ERISA;

—ERISA preempts state mandated benefit laws and thereby prevents states from applying these laws to self-funded health plans;

—ERISA provides participants with no protection from unilateral and discriminatory termination of benefits, exclusions;

—ERISA provides no assurance that participants will receive timely and understandable disclosure of the terms and operation of their health plan coverage, deprives participants of any state court remedy if they are misled, and allows the most crass manipulation of the terms of health plans at the expense of participants and their children or dependents;

—ERISA preempts a state cause of action for "managed care malpractice," but does not itself provide an administrative remedy for negligent or intentional malfeasance in the administration of managed care plans. The only recovery ERISA allows is a recovery of plan benefits.

Needed ERISA Market Reforms

Any revision of ERISA that takes place in the course of reforming the health care system should do several things to assure that consumers are protected in terms of market conduct:

—Recognize that "accountable health care plans" act as insurers and that they should be subject to regulation as such;

—Clearly delineate the agencies that are responsible for the regulation of "accountable health plans";

—Ensure that both insured and self-funded health benefit plans conform to specified standards;

—Ensure that insured and self-funded plans provide clear and understandable disclosure of the terms of the plan;

—Either prohibit discriminatory termination of benefits by amendment to the health plan or allow for specification of the benefits which must be provided under a health plan by statute, regulation or a designated party;

—Require "portability," i.e., prohibit insured and, self-funded health plans from denying coverage of preexisting health conditions after a participant changes coverage from one plan to another;

—Ensure that entities that perform utilization review, pre-authorization review, or claims adjudication functions for insured or self-funded health plans are subject to performance standards and compliance enforcement and auditing;

—Encourage the application of quality control measures to insured and selffunded health plans; and

—Provide appropriate protection for the privacy and confidentiality of individually identifiable participant information.

Essential Regulatory Functions: Market Conduct

The NAIC believes that consumer protection demands that any health care reforms consider certain key regulatory functions dealing with market conduct.

LICENSING OF COMPANIES

State regulators consider it essential that any health care reform plan designate the agency that will be responsible for assuring that only fiscally sound entities with responsible, reputable management be licensed to do business. This agency should have the authority and the tools to assure that businesses that participate in the marketplace have sufficient capacity and sufficient resources to provide the promised services to consumers.

LICENSING OF AGENTS

Similarly, a state agency should oversee the activities of the people that provide information, education, and consulting services to consumers regarding consumer choices. This oversight function should address both the people themselves—their qualifications, competence, and reputation—and the accuracy and veracity of the information they provide to consumers.

POLICY FORM COMPLIANCE

There will be a continuing need to assure that health care coverage policies and plans comply with the law and with standard benefit and other legal requirements. In addition, there will be & need to assure that any supplemental benefit policies offered to consumers are in compliance with legal or regulatory standards.

DATA AND CONFIDENTIALITY

There must be explicit standards for collecting and protecting data for claims payment, performance monitoring, and for the establishment of health policy.

UNFAIR TRADE AND CLAIMS PRACTICES

An effective health reform plan should assure fair conduct in the marketplace and include provisions to assure:

—fair and accurate claims settlement,
—accuracy and fairness in advertising,
—fair marketing,
—fair application of "medical necessity" criteria, and
—sufficient provider networks.

SOLVENCY

Actions by State Regulators and the NAIC

FINANCIAL REGULATION STANDARDS AND ACCREDITATION PROGRAM

A key component of the consumer protection responsibilities of insurance regulators is the obligation to assure that insurers remain solvent so that they can fulfill their promises to consumers to pay claims. Insurance regulators use a broad array of tools to, regulate for solvency, including on-site financial examinations; off-site financial analyses; restrictions on the business and investment practices of insurers, agents, and others in the industry, to mention just a few.

The NAIC has adopted national baseline standards for effective solvency regulation, under the Financial Regulation Standards and Accreditation Program. This program, begun by the NAIC in 1990, establishes regulatory standards in three categories: (1) laws and regulations, (2) regulatory practices and procedures, and (3) organizational practices and procedures. In order to be accredited by the NAIC, a state must be deemed by an independent team of regulatory experts to be in compliance with these rigorous standards.

The NAIC's accreditation program has already been quite successful in upgrading the quality of regulation across the country. Every state has adopted laws in an effort to comply with the standards. Furthermore, state legislatures have responded to the program by expanding regulatory budgets at roughly three times the rate that general state budgets have increased, and far more rapidly than the budgets of federal regulators of financial institutions. Thirty-two states are now accredited, and we expect many more to apply for accreditation in 1994. A booklet providing greater detail on the NAIC's Financial Regulation Standards and Accreditation Program is attached as Attachment B.

RISK-BASED CAPITAL REQUIREMENTS

The most recent addition to the NAIC's solvency standards is of particular relevance today—the Life/Health Risk Based Capital Model Act, adopted by the NAIC in December 1992 and added to the NAIC's solvency standards last September.

State laws generally require insurers to maintain minimum levels of capital or surplus. Historically, insurers' capital and surplus requirements have been established by law at a fixed amount for each major line of insurance. In recent years, the less conservative business practices of some insurers ran headlong into the economic troubles of the late 1980s and created an increase in the failure of insurance companies, to the detriment of insurance consumers, policyholders, claimants, and taxpayers.

In 1990, a NAIC panel examined both the existing capital requirements and this growing diversification in insurer business practices, and concluded that companies that assume a more aggressive, risk-taking approach must protect their consumers from the financial hazards created by that risk-taking through the establishment of higher capital standards. After extensive research and expert advice, the NAIC adopted life/health risk-based capital requirements in December 1992, and adopted property/casualty risk-based capital requirements in December 1993.

First, I will describe in some detail the life/health risk-based capital requirements, because such risk-based capital requirements are already affecting some providers of health insurance. Then, I will describe the NAIC's current efforts to draw from our experience in the life/health arena to craft risk-based capital requirements for health organizations in addition to life/health insurers.

LIFE/HEALTH RISK-BASED CAPITAL REQUIREMENTS

The NAIC's life/health risk-based capital project covers all insurers that report their annual financial results on the NAIC's life/health annual statement blank (generally, life companies that sell health insurance). It is most easily understood in two segments—the formula and the model law. The formula provides for each insurer to calculate and report its risk-based capital requirement and its total adjusted capital. The model law then assigns legal and regulatory significance to the relative levels of those two numbers.

THE CALCULATION OF THE RISK-BASED CAPITAL REQUIREMENT

Four types of risk—asset risk, insurance risk, interest risk, and business risk—go into the calculation of a life insurer's risk-based capital requirement.

"Asset risk" is the risk of asset default for debt assets and loss in market value for equity assets. "Insurance risk" is the risk that claims might exceed expectations, both from random fluctuations and from not making adequate provision in the pricing for certain unexpected risks. The "interest rate risk" is the risk of losses due to changes in interest rate levels. The "business risk" is the risk that, because of the failure of other insurers, the insurer in question would be charged & guaranty fund assessment.

These four types of risks are combined in a formula that produces the company's "Authorized Control Level Risk-Based Capital," which then serves as a standard for regulatory action. The purpose of the formula is to estimate the capital levels required to deal with losses, which may be caused by a catastrophic financial event.

THE REGULATORY IMPACT OF THE FORMULA

The formula provides a mechanism for the calculation of an insurance company's Authorized Control Level Risk-Based Capital and its Total Adjusted Capital. The model law provides a commissioner with the authority to place an insurer under state control once the company's Total Adjusted Capital has fallen below the Authorized Control Level RBC.

The first level is known as the Company Action Level RBC, which is set at twice the Authorized Control Level RBC. The second level is the Regulatory Action Level RBC, at 1.5 times the Authorized Control Level RBC. The third is the Authorized Control Level RBC, and the fourth is the Mandatory Control Level RBC, Set at 70 percent of the Authorized Control Level RBC.

If a company files an RBC report that indicates that the Total Adjusted Capital is higher than the Regulatory Action Level RBC and lower than the Company Action Level RBC, the insurer must submit to the insurance commissioner a comprehensive financial plan. If a company's capital falls between the Regulatory Action Level RBC and the Authorized Control Level RBC, the commissioner shall perform such examination or analysis as he or she deems necessary of the insurer's business and operations and issue any appropriate corrective orders to address the company's financial problems.

If a company's Total Adjusted Capital falls below the Authorized Control Level RBC, the commissioner may place the insurer under regulatory control. Finally, if a company's Total Adjusted Capital falls below the Mandatory Control Level RBC, the commissioner will be required to place the insurer under regulatory control.

THE DEVELOPMENT OF RISK-BASED CAPITAL REQUIREMENTS FOR HEALTH ORGANIZATIONS

In 1993, the NAIC created the Health Organization Risk Based Capital Working Group. That panel is developing a separate risk-based capital formula for health organizations other than health insurers, including health maintenance organizations (HMOs), Blue Cross/Blue Shield (BCBS) plans, and health service plans. This is necessary because the risk-profile differences between health organizations and health insurers can be substantial.

For example, insurance companies invest extensively in marketable securities, and the risk-based capital factors are set accordingly. However, some health organizations have substantial assets in ventures—such as hospitals—which are used directly in providing services and therefore contribute directly to the health organization's ability to control quantity and cost of services. Also, some have suggested that health organizations transfer risk differently than do health insurers, with the former using such devices as negotiated fee schedules, budgets, and capitation rate agreements, the latter focusing on reinsurance and stop-loss coverage.

The working group is addressing all these issues, along with many others. It is our goal to develop a seamless system of risk-based capital requirements that will be appropriate for the existing environment and accommodate future evolution as well. This should facilitate an even playing field for health insurers, BCBS plans, HMOs, and others, while not stifling the development of innovations.

Naturally, we will keep the Congress informed as to this group's progress.

FIFTY-STATE ADOPTION OF GUARANTY FUNDS FOR LIFE/HEALTH INSURERS

Providing a safety net for insurance consumers in the event of insurer failure is an essential component of consumer protection. Indeed, 400,000 Americans have

been victimized by health insurance scams under ERISA—an arena in which there is no safety net. Such scams include multiple employer welfare arrangements (MEWAs) that fraudulently claim ERISA preemption from state insurance regulation. By contrast, since 1991, every state in the nation has had a health insurance guaranty fund to provide consumers whose insurers have failed with guaranty fund protection. Furthermore, since then, the NAIC and the states have taken significant efforts to improve the coverage of those funds and to fill the remaining gaps in the system.

ERISA and Solvency: Limitations and Needed Reforms

ERISA's solvency-related problems

As is the case in the arena of market conduct, ERISA creates problems in the arena of solvency regulation. Let me give you an example.

In 1989 & Wisconsin-based Taft-Hartley Fund failed. It left more than $3 million in health coverage claims unpaid for hundreds of workers and their dependents located in the Midwest. Attorneys for the participants claimed that the fund failed because it was mismanaged, failed to maintain adequate reserves, charged inadequate rates, and misrepresented its financial condition.

A congressman investigating this matter was advised by the U.S. Department of Labor that fund participants should look to the state insurance department for assistance. Many fund participants assumed that the fund was regulated as an insurer by the state insurance department because the fund had acted as a health insurer for them. In fact, dozens of fund participants filed complaints with the insurance department; many such participants were being hounded by health care providers for payment of amounts they could not possibly afford. Participants wondered why the state insurance department had not acted to prevent the insolvency and asked what governmental agency would pay the obligations of the insolvency fund.

The U.S. Department of Labor soon acknowledged that, under ERISA, the fund was under its exclusive jurisdiction. Yet ERISA provided little or no financial regulation of the fund, there was no governmental agency that would fulfill the fund's obligations, and the Department of Labor had no real capacity to assist complaining participants. In other words, ERISA left the fund participants without a remedy.

Participants in insured health plans, which are regulated by state law, enjoy greater protections than participants in self-funded plans in terms of solvency oversight and post-insolvency remedies. Let me mention just & few of ERISA's solvency problems.

In drafting ERISA, Congress included few restrictions on self-funded health plans. In addition to its failure to provide standards for the initial financing of self-funded plans, Congress did not establish any standards to regulate the continued solvency of plans once they went into operation. Self-funded health plans are virtually free to operate without any meaningful standards or oversight.

Worse yet, ERISA provides no financial safety net for health plan beneficiaries, in sharp contrast to state guaranty funds, which undergird insured plans, and the Pension Benefits Guarantee Corporation, which serves as a safety net for pension plans. The only recourse for self-funded plan participants who seek redress against an insolvent health plan is to stand in line with the rest of the employer's creditors and hope for pennies on the dollar as the employer's assets are divided among claimants.

ERISA reforms

Several changes to ERISA must be made to assure that consumers are protected in the area of solvency regulation. Specifically, ERISA should be amended to:

—Require single employer self-funded health plans to meet financial standards;

—Provide for initial capital requirements for accountable health plans;

—Provide for risk-based capital requirements for accountable health plans; and

—Provide effective protection for participants in the event of insolvency of accountable health plans, including provisions for liquidation and guaranty fund coverage.

Essential Regulatory Functions: Solvency

The NAIC believes that consumer protection demands that any health care reform include certain key financial regulation elements.

AUDITS

There must be a state entity charged with conducting continuing operations and compliance audits of health plans. These audits should include both financial audits (to assure plan solvency) and performance audits (to assure compliance with market conduct laws and regulations).

CONTINUITY OF ACCESS

A health reform plan should have a mechanism to assure that a consumer's access to health care coverage is not jeopardized should the consumer's insurer or health plan become financially unsound.

NON-BIFURCATION OF SOLVENCY AND RATE REGULATION

On several occasions, the NAIC has appeared before congressional subcommittees to make the point, among others, that rate regulation and solvency regulation should be kept in the same hands. We believe this is true because of the inherent tension between rates and solvency. In short, the commitment by regulators to assure that rates are reasonable contends with the countervailing commitment to assure that rates are adequate to maintain company solvency.

We have generally made this argument in the context of proposals to move some or all of solvency regulation to the federal level and keep rate regulation at the state level. What is striking about today's hearing is that it is in the context of at least one proposal—the President's—that would keep solvency oversight at the state level and move rate regulation to the federal level, by way of premium caps.

The NAIC has taken no position on whether a health reform plan should include federally established premium caps. However, we do want to reiterate our general concern regarding the bifurcation of solvency and rate regulation. In other words, while we neither support nor oppose premium caps, we want to assure that if they are part of the health reform ultimately approved by the Congress and the President, the legislation must contain provisions to protect consumers from the potential negative consequences of the division of regulatory authority.

THE ACCURACY OF PREMIUM CAPS

We have an additional concern about premium caps—that the calculation of any such caps be based upon solid information. Naturally, it is vital that, should reform contain any ceilings on premiums, those ceilings be based upon reliable and relevant information. Our concern arises out of the fact that the data from the current system is inadequate at the federal level and not uniform at the state level.

This is a particularly serious issue because the consequences of establishing initial ceiling limits that &re wrong could be enormous and sustained. Significant underpricing could jeopardize the ability of the system to meet its claims obligations, and significant overpricing could hurt the nation's economy.

CONSUMER INFORMATION AND COMPLAINTS

There are two important aspects of providing consumers with adequate protection in any regulated market. One involves assuring that buyers have accurate, meaningful, and sufficient information to make an informed purchase. Second, aggrieved consumers should have ready access to & government agency with either the power to assist consumers or the ability to resolve problems through an administrative procedure.

ACTIONS BY STATE REGULATORS AND THE NAIC

The NAIC has adopted a series of model acts and regulations that address the quality of disclosure in group health insurance contracts. Either through those model laws or through laws and regulations developed independently of the NAIC, most states have standardized the terminology, benefits, and provisions included in a group health insurance contract to a certain degree. Additionally, all states require insurers to obtain regulatory review and approval of their group health insurance contracts and certificates, and that review is to determine that the contracts conform to standardization requirements, are not misleading, and are written in clear language.

The NAIC Complaint Database System (CDS) provides on-line access to the aggregated complaint data from one, several, or all jurisdictions, as well as summary reports, trending, and complaint ratios. As of October 1993, 25 states were providing comprehensive consumer complaint information to the CDS, which now contains

592,000 complaint entries. Already, in just the first 18 months CDS has been on-line, the states have made over 6,000 inquiries of the system.

In order to increase consumer participation in the NAIC's decision-making process and remove some of the barriers to that participation, the NAIC operates a Consumer Participation Program. Under that program, the NAIC provides funding for travel by consumer representatives to NAIC meetings across the nation and throughout the year. That program has been most successful in increasing consumer involvement in the establishment of insurance regulatory policy.

ERISA AND CONSUMER RELATIONS: LIMITATIONS AND NEEDED REFORMS

ERISA'S CONSUMER RELATIONS PROBLEMS

ERISA does require plan administrators to provide accurate, comprehensive, and understandable summaries of benefit plans to plan participants. However, such documents are not reviewed by any administrative agency. Furthermore, if a plan administrator violates the disclosure requirement, a consumer that is misled by the disclosure has no state court or administrative remedies.

ERISA REFORMS

The NAIC recommends that ERISA be revised in several respects:

—To require that each insured or self-funded health plan provides an easily accessible and meaningful grievance procedure.

—To require each insured or self-funded health plan to provide independent alternative dispute resolution mechanisms to mediate or adjudicate disputes with participants.

—To assure that every participant in an insured or self-funded health plan has easy access to a state agency that provides meaningful assistance to participants relating to their complaints against the health plan.

—To give participants in insured or self-funded health plans full access to state court remedies.

ESSENTIAL REGULATORY FUNCTIONS: CONSUMER INFORMATION AND COMPLAINTS

Additionally, any health care reform plan must include an effective mechanism for providing consumer assistance and a clear and unbiased consumer grievance process. The system should include similarly fair procedures for appeals from the decisions made by the initial dispute resolution body.

CONCLUSION

State insurance regulators can be proud of their record of protecting health care consumers. We have a solid record of financial and market regulation, and are at the cutting edge of the reform of the health care system. As I have explained, the reach of our reform efforts is unduly limited by the barriers created by ERISA. Worse yet, the portion of the health care market covered by ERISA is in desperate need of reform. The task of fixing ERISA's ills is squarely in the lap of the Congress.

The complicated and shifting nature of insurance presents a formidable challenge to the Congress and the President as you work on a national health reform plan. We believe we can help with that effort, providing technical resources and expertise throughout the process. Most of all, while we do not have all the answers, we do know most of the questions that need to be answered in order to design a system that works. We look forward to continuing to work with you in the coming months.

Again, thank you for this opportunity to testify.

[Editors note.—Due to the high cost of printing, the attachments supplied are retained in the files of the committee.]

Senator METZENBAUM. The Chair will have a couple of questions, but he will be rather brief because there is a roll call on and I must get to the floor before that.

Ms. Nichols, are you saying that managed care is a zero sum gain? That what managed care saves from reduced fees to doctors and hospitals, it spends in an equivalent amount on administrative oversight and overhead?

Ms. NICHOLS. What I am saying, Mr. Chairman, is that there are no appreciable savings from managed competition, and the only

conclusion we can reach is that the savings that come from reduced care are being eaten up by administrative overhead and excess profits. And so I guess the answer to your question would be yes. It may even be less than a zero sum gain, because you may end up spending more on administrative overhead than you save. And of course, there is the reduced quality of care.

Senator METZENBAUM. Would it make sense for Congress to make it illegal for a health care plan to provide doctors the financial incentive to deny health care such as bonuses for running fewer tests or staying within certain limits for referrals to specialists? Should we make it illegal?

Ms. NICHOLS. I do not know what the answer to that question should be, Mr. Chairman. I think that we should consider reversing the perverse incentives that are there, but I think even more importantly we should change the way health care is financed, so that we do not have to try to control costs in that manner. It is the wrong way to go about it. We need to do it on a global level through budgets and rate setting.

Senator METZENBAUM. Ms. Shearer, I am concerned that in most of the talk about health care reform very few people talk about protecting patients. Under a reform system, whom do you believe should represent the interest of patients and how should they do so?

Ms. SHEARER. Let me just start by responding by saying that we often hear that doctors should represent patients or we hear that insurance companies are representing their insurance policyholders. We think that under reform the system has to ultimately be accountable to consumers and not insurance companies. So we want to see a structure, if there are going to be alliances and we want to see consumers and employers running those alliances. When appointments are made to a national health board, we want to make sure that they are representing consumers and not providers of care. And I think the ultimate test is going to be, is the system accountable to the profitability of insurance companies or is it accountable to consumers.

Senator METZENBAUM. Do you think the AMA and the medical groups ought to have an exemption from the anti-trust laws under the new legislation?

Ms. SHEARER. No, we do not. We are troubled by this provision and the plan that allows doctors to collude and go before the regional alliance meet beforehand about how prices should be set. We are very troubled by that provision.

Senator METZENBAUM. As you know, so am I. Ms. Nichols, do you agree that the exemption from the anti-trust laws is entirely inappropriate?

Ms. NICHOLS. Absolutely.

Senator METZENBAUM. I think your voices ought to be heard loud and clear, and that includes you, Ms. Dallek, in your group, because that exemption is in the law and the proposed Clinton administration plan. And this Senator has made it very clear that that is a totally unacceptable provision.

What needs to be done to maintain the quality of our health care system in light of the increased corporatization of health care, Ms. Dallek?

Ms. DALLEK. Let me just say, I think that managed care is a juggernaut that cannot be stopped now. If that is the case, we just need to look at California to know that. I think that is true. If that is the case, we need a great deal more consumer protections. We need them now and we need them to be very strong. The Department of Insurance and certainly the Department of Corporation in California, which monitors managed care, does—I know in California, it does a lousy job of monitoring HMOs. And I think we can see that in a number of other States.

In terms of Medicaid, HMOs do not do a good job. In terms of Medicare, HCFA, we cannot get any quality of care information. We need much, much stronger patient protection in terms of again, the appeals' process, in terms of getting information out to folks, and in terms of getting outside monitoring review. And I think that has to be done right now.

Senator METZENBAUM. Mr. Lyons is here and actually testified that the State Insurance Departments ought to have more authority in monitoring the HMOs, the managed care plans. And I am frank to say that some State insurance commissioners and Mr. Lyons is one of them, do do a good job. But a hell of a lot of them do a lousy job. And too many of them are interested in their former employer which was an insurance company or they are worried about their next job.

Do you have any confidence in the Insurance Departments of the various States in order to see to it that there is decent supervision of managed care? Mr. Lyons, you know my concerns and I think you have been trying to do a good job, but even now I think your task force recently came forward with something, I think, on assume risk, if I am not mistaken? Am I correct about that?

Mr. LYONS. We have responded in several areas in conjunction with your office.

Senator METZENBAUM. But now I am worried about how long it will take the States to move in that direction and it is a slow process, sometimes as long as 20 years. Would you care to respond?

Mr. LYONS. Let me respond on the issue of HMOs and managed care. They are twofold. One, a lot of the managed care which is occurring right now is under ERISA plans. And there is nothing I can do about the case where coverages are dropped or the H&H Music case, where as soon as a person becomes HIV infected, suddenly the insurance policy is changed and that person has no access to any decent lifetime benefits. I have no jurisdiction there. So we need to expand the jurisdiction to be able to affect ERISA-style cases. And when we get into managed care, I will agree on the record that we can do a better job. Managed care has some issues that are coming up that we need to respond to quickly and effectively.

We have a project called the quality and accountability standards, and some people in this room will be familiar with it because we have invited in health officials, State officials, Federal officials, and consumer groups to work with us. Here are the minimum eight project areas under quality and accountability standards for managed care.

Senator METZENBAUM. Do not recite them all. I have got to get to the floor for a vote.

Mr. LYONS. OK, quality assurance, utilization management, grievance procedures, credentialing, provider contracting, confidentiality, data reporting and accessibility standards. And I think everyone testifying here agrees that we need to have some pretty strong recommendations out there to get past in the States, so we can regulate adequately in a managed care environment.

Senator METZENBAUM. Please forgive me for having to run on you, but I have a few more questions. We may send you letters and ask you for your responses. But I do not want to miss the vote that is on the floor. Thank you, and the hearing stands adjourned.

[Additional statements and material submitted for the record follows:]

CHRONOLOGY

The following chronology is based on the medical records (Tab A) and the deposition testimony given to date. It shows how this tragedy unfolded despite Karin Smith's persistent attempts to have her condition diagnosed.

1986 9/3/86 Karin has initial annual physical and Pap. Cervical exam is negative. Pap smear is negative. (Confirmed by plaintiffs' expert cytotechnologist, Gail Borkowski-Klein.)

10/28/86 Karin starts birth control pills.

1987 2/18/87 Karin complains of severe menses since-starting birth control pills. Cervical exam shows erosion and slight friability. She is switched from Ortho Novum to Low Ovral birth control pills.

9/15/87 Karin has second annual exam and Pap. First complains of post-coital bleeding: "two instances in past month". Karin switches from birth control pills to diaphragm and condoms because of continued dysmenorrhea. Cervix seen as healthy with erosion and friability. Pap smear negative. (Confirmed by Borkowski-Klein).

1988 6/23/88 Karin's initial visit to FHP-Airport Clinic. Pap and pelvic exam is done by physician's assistant. Karin advises of history of one and one-half years of post-coital bleeding, "but not after every intercourse". Karin also expresses desire to start on birth control pills. P.A.'s exam of cervix finds slight ectropion, no masses and no tenderness. Pap smear is taken and sent to CBC pursuant to capitation agreement.

6/27/88 June Fricano misreads Pap smear as "negative, Class I" (Fricano now admits that Pap smear, correctly read, is "suggestive of adenocarcinoma, Class IV").

1989 4/13/89 Karin returns to FHP-Airport for exam. Seen by P.A. Complains of vaginal bleeding after intercourse for two and one-half years. Now occurring every fourth or fifth time. Bleeding is fairly profuse, like a period, and lasts a day. Cervix shows ectropion on exam. Two-slide Pap smear is taken. Pap smear is sent to CBC pursuant to capitation agreement. Referral is made to Dr. O'Reilly, OB-GYN, pursuant to FHP-Airport capitation agreement.

4/17/89 Fricano misreads Pap smear as "negative, Class I" (Fricano now admits that Pap smear, correctly read, is "suggestive of adenocarcinoma, Class IV").

5/23/89 Karin first sees Dr. O'Reilly pursuant to capitation agreement. Dr. O'Reilly recommends colposcopy.

6/7/89 Dr. O'Reilly performs colposcopy. Notes abnormal cervix with acetowhite, punctation and metaplasia. Biopsies done at 4:00

and 12:00 positions on cervix. Biopsies sent to CBC as required by FHP capitation agreement.

6/8/89 Without clinical history, Dr. Molot does macroscopic exam of biopsies.

6/12/89 Without clinical history, Dr. Molot does microscopic exam of biopsies. Dr. Molot describes "papillary pattern" of cells. Erroneously concludes "microglandular hyperplasia" (Dr. Lipo states at his deposition that biopsies do not show garden variety microglandular hyperplasia. Dr. Montag and the other pathologists retained by plaintiffs state that the biopsies show adenocarcinoma and that "papillary pattern" is one of its recognized characteristics.)

6/21/89 Dr. O'Reilly, in reliance on misdiagnosis, does cryosurgery on Karin to treat "excessively large area of transformation zone with squamous metaplasia. Increased discharge and spotting."

10/16/89 Karin calls Dr. O'Reilly and tells her of continued spotting.

11/30/89 Karin sees Dr. O'Reilly on referral from FHP-Airport. Dr. O'Reilly notes that cervix is "very vascular", biopsies cervix, and orders tests which rule out bleeding disorder. Biopsy sent to CBC pursuant to capitation agreement. Karin is taken off birth control pills because of pathological diagnosis of "microglandular hyperplasia". No entry is made in Karin's FHP chart that she has been taken off birth control pills to treat the microglandular hyperplasia.

12/5/89 Dr. Biller examines biopsy without clinical history, and without knowledge of prior biopsy at CBC. Dr. Biller misreads biopsy as "microglandular metaplasia" despite recognition of "papillary configuration" of cells (Dr. Biller still stands by his diagnosis even though Karin's clear cell adenocarcinoma is unquestioned). (Dr. Lipo admits that biopsy does not show "garden variety microglandular hyperplasia". Dr. Montag and all other pathologists retained by plaintiffs state biopsy unquestionably shows adenocarcinoma, not microglandular metaplasia.)

12/89 to 5/7/90 Karin is off birth control pills but continues to have post coital bleeding. Karin also transfers from FHP-Airport to FHP-Bluemound. Dr. Olson of FHP-Bluemound replaces Dr. Agoncillo of FHP-Airport as Karin's primary doctor.

1990 5/7/90 Karin calls FHP-Bluemound for refill of birth control pills. Bluemound Pharmacy requests Dr. Olson to "write out Rx and send it to Pharmacy". Dr. Olson writes prescription without talking to Karin, examining Karin, consulting Karin's chart or learning that she was off birth control pills for treatment purposes.

6/8/90 Karin has telephone conversation with Dr. Olson and tells him she has been bleeding including the four days since restarting birth control pills. Dr. Olson tells Karin to go off pill for six months, and follow up if post-coital bleeding continues.

6/10/90 Karin calls FHP with complaint of vaginal bleeding for 10 days and having passed blood clot that day.

6/11/90 Karin walks in to FHP and gives history of vaginal bleeding for 15 days, passage of clot on day prior, post-coital bleeding for one year with gushing for two days; saw OB-GYN five times for problem without solution. Started continuous bleeding after intercourse on Tuesday, followed by pill on Sunday. Dr. Olson sees Karin, but does no examination. Dr. Olson performs pregnancy test which is negative. Tells Karin to discontinue birth control pills and see him in six months.

6/18/90 Karin calls FHP, tells them that she has been bleeding for 21 days and passed out night before. RN tells Karin to take juice with sugar then follow with high protein food and call back in 45 minutes. Karin calls back and says feeling better.

6/21/90 Karin calls FHP complaining of 24 days of continuous bleeding. Makes appointment to see Dr. Bower.

6/22/90 Karin sees Dr. Bower. Advises him of history of 24 days of bleeding, 2-3 weeks abstention from intercourse, prior biopsies showing "cervicitis relating to pill" and discontinuation of pill 10 days previous. Dr. Bower examines cervix and notes beefy red cervicitis, quite friable. Pap smear is taken and sent to CBC per capitation agreement. Dr. Bower orders follow-up with Dr. Olson and referral to gynecologist for cryosurgery or colposcopy. Karin requests referral to Dr. O'Reilly. Dr. Bower refuses because FHP-Bluemound's capitation agreement is with Dr. Chambers and FHP-Airport's is with Dr. O'Reilly. Dr. Bower orders pathology reports and Dr. O'Reilly's "consult" be sent to Dr. Chambers. FHP contains no "consult" only a letter from Dr. O'Reilly recommending colposcopy.

6/25/90 Fricano reads Pap smear as abnormal. Biller reports Pap smear as "atypical cells suggestive of being glandular in origin. Recommend colposcopy and biopsy to rule out malignancy". Neither Fricano nor Biller rescreen prior Pap smears or biopsies as CBC has no system notifying them of prior tests or requiring retrieval and rescreen of prior tests.

7/5/90 Karin informed of abnormal Pap and referral to Dr. Chambers.

7/10/90 Karin sees Dr. Chambers. Dr. Chambers' history has no mention of post-coital bleeding or discontinuation of birth control pills; he does not call Dr. O'Reilly. Dr. Chambers does take history of 35 days of bleeding leading to appointment and of abnormal Pap. He records that prior biopsies revealed microglandular hyperplasia and pathology reports suggested relationship with birth control pills (Dr. Hoogerland, Karin's present treating gyn-oncologist, has testified that there is no association between microglandular hyperplasia and post-coital bleeding, that it does not explain Karin's post-coital bleeding and that it is, at best, an incidental finding). Dr. Chambers examines cervix and notes "marked exophytic type lesion on the cervix that looked glandular in etiology. There were large vessels running across the lesions." (Both abnormalities associated with cervical cancer.) Dr. Chambers biopsies the cervix at three sites. Pursuant to the capitation agreement with FHP, the biopsies are sent to CBC.

7/13/90 Dr. Biller misreads the biopsies as squamous metaplasia and microcystic "mucoid metaplasia". Dr. Biller reads biopsy without benefit of clinical history, knowledge of abnormal Pap or knowledge of prior cervical biopsies. Dr. Biller again notes "papillary-like configuration " of tissue. ("Mucoid" describes clear cells and Biller's conclusion of mucin as cause. Clear cells are also caused by glycogen secondary to adenocarcinoma; hence "clear cell adenocarcinoma". Biller does not perform test to differentiate between "mucin" and "glycogen".)

7/20/90 Dr. Chambers calls Dr. Bower and advises that biopsies showed hyperplasia and recommends Karin discontinue birth control pill and follow up in one year.

9/27/90 Karin calls FHP for referral to Dr. Chambers for irregular periods.

10/19/90 Karin sees Dr. Chambers. She gives him history of "irregular bleeding and spotting almost on a daily basis. The patient has refrained from sexual relations because she bleeds heavily following sexual relations." Dr. Chambers recommends cautery of cervix.

11/20/90 Karin calls FHP for appointment for blood work because she is experiencing "long periods/20 days. Tired, weak, always feeling sick past 5 months."

11/29/90 Karin calls FHP with complaint of continued bleeding for 25 days. "Going on like this for 5 months." Dr. Olson calls Karin back and suggests she may need to follow up with Dr. Chambers. Dr. Olson concludes, "No acute need".

12/4/90 Karin sees Dr. Chambers for first cervical cauterization procedure. Dr. Chambers cauterizes top half of cervix and prescribes Aci-Jel.

12/11/90 Dr. Chambers performs second cautery.

1991 1/8/91 Dr. Chambers performs third cautery.

1/30/91 Call to Dr. Chambers office: "Significant problem with continued bleeding".

1/30/91 FHP authorizes Karin to make three follow-up visits to Dr. Chambers.

4/2/91 Karin calls FHP for authorization of 4-5 referrals to Dr. Chambers for ongoing three-year bleeding problem.

4/3/91 FHP authorizes three follow-up visits.

4/26/91 Karin sees Dr. Chambers for continued bleeding problem. Dr. Chambers suggests Karin see his partner, Dr. Sander, for laser therapy.

5/15/91 Karin goes "out of FHP" to see Dr. Stewart. Dr. Stewart examines cervix and notes " P.E. is really something. Red cauliflower. Red cervix. This is actually a growth. It bleeds like crazy. Bimanual is very upsetting as cervix and neck is up and down hard. This is worrisome. Needs gyn oncologist. Expert colpo. and needs this operated." Dr. Stewart calls Dr. Hoogerland and notes Hoogerland "agrees-worrisome. Have to think of adenocarcinoma of cervix." (Dr. Hoogerland testified that Dr. Stewart called him at home in evening, a very unusual event, and told Dr. Hoogerland that he felt Karin had cancer.)

5/16/91 Karin sees Dr. Olson for same day referral to Dr. Hoogerland. Dr. Olson writes referral indicating suspicion of cancer and need to see referral "as soon as possible". FHP Patient Services denies referral because referral made by Dr. Stewart an "out of plan physician."

5/17/91 Dr. Olson talks to FHP Patient Services regarding denial of referral. Patient Services says that Karin can go but "has to pay for visit herself". She can keep her bills and "come before a medical review committee." Patient Services overruled and referral faxed to Dr. Hoogerland.

5/17/91 Karin seen by Dr. Hoogerland. He cannot rule out malignancy and recommends conization.

5/21/91 FHP approves conization but requires that it be done at St. Michael's, an FHPC hospital, and authorizes one follow-up visit. Dr. Hoogerland insists on operation at St. Mary's Hospital, a non-FHPC hospital. FHP approves St. Mary's 5/29/91.

5/29/91 Dr. Hoogerland does conization at St. Mary's. Clear cell adenocarcinoma of cervix is diagnosed.

The chronology is long and contains numerous entries spanning over three years. What it emphatically demonstrates is that the delay in diagnosing Karin's cancer was long and the diagnosis repeatedly blown. The adenocarcinoma was literally there to see on:

6/88 Pap smear
4/89 Pap smear
6/89 biopsy
12/89 biopsy
6/90 Pap smear
7/90 biopsy

The clinical indications of significant post-coital bleeding, change in frequency and character of bleeding, and abnormally vascular cervix are charted by either FHP-Bluemound or Dr. Chambers on:

6/8,10,11,18,21,22/90
7/20, 9/27, 10/19, 11/20,29, 12/4/90
1/30, 4/2,26/91.

The chronology graphically demonstrates what happens when continuity of care is lost and money is saved by sending life saving tests to a cost saving lab. It demonstrates what happens when a doctor puts his clinical head in the sand and ignores the obvious explanation for significant post-coital bleeding and a grossly abnormal cervix. It demonstrates what happens when a patient is "processed" by multiple health care providers who don't consult with one another or someone "outside the plan." It also demonstrates what happens when the announced goal of FHP is:

"I wouldn't want Dr. Lipo to have an excessive rate of pay for providing services that were not in keeping with the competitive market place. That would be impropitious." (sic) (Bradford Dep II, p. 92.)

NEGLIGENCE

Family Health Plan

Any analysis of liability begins with FHP. Just like a conductor, FHP orchestrated the bidding process, the capitation agreements and the selection of providers. Unfortunately for Karin Smith, FHP more closely resembles Charlie Chaplin than Leonard Bernstein and the providers more closely resemble the Keystone Cops than trained musicians. For example:

1) FHP hired June Fricano as its cytology supervisor after learning Damon Corp. terminated her for falsifying records (Bradford Dep I p. 37, Dep II p. 52).

2) David Bradford, a former physician's assistant at FHP, led the team that annually inspected CBC-Clinilab during Lipo's ownership (Bradford Dep II p. 28, 30). This "inspection team", inspecting a lab that did Pap smears and gynecological biopsies, lacked anyone with expertise in cytology or pathology (Bradford Dep II p. 30).

3) Dr. Chaillet, FHP's Medical Director, read the 1987 Wall Street Journal article exposing Pap Mills where cytotechs were paid by the slide, encouraged to read as many as 100 slides a day and missed diagnosing cancer because of it (Chaillet Dep. p. 86). Despite knowing of this scandal, FHP's "Medical Director" never inquired of officer-director Lipo concerning CBC's cancer screening program (Chaillet Dep. p. 87). Instead, Dr. Chaillet relied on Dr. Lipo to admit to running a Pap Mill (and thereby lose his livelihood) (Chaillet Dep. p. 91). FHP effectively delegated its responsibility to monitor the lab to Dr. Lipo. In more colloquial terms, FHP relied on the fox to guard the hen house.

FHP blames Dr. Lipo. Dr. Chaillet testified that Dr. Lipo had a duty to tell FHP that Fricano read more than two times the maximum recommended number of slides (Chaillet Dep. p. 89, 91). Had Dr. Chaillet known of such conduct, FHP would have investigated CBC and the contract would not have been renewed (Chaillet Dep. p.79, 84, 89). Bradford, ever mindful of the bottom line, hedged somewhat. He testified that had he known of the practice, he would want to check out the situation before terminating his low bid vendor (Bradford Dep II p. 119). In other words, cytological guidelines must be weighed against cost effectiveness.

While Dr. Chaillet correctly defines Dr. Lipo's duty, blaming Dr. Lipo does not exonerate FHP. As an officer and director of both CBC and FHP, Dr. Lipo carried the knowledge of the abuses out of one boardroom and into the other. Joachim v. Wisconsin Dental Clinic, 219 Wis. 35 261 N.W. 745 (1935). Dr. Lipo knew June Fricano bragged about reading 30 slides an hour (Lipo Dep. p. 127). Because Lipo knew, FHP knew. Dr. Lipo knew that Fricano read more than 200 slides a day for CBC (Lipo Dep. p. 96, 123). Because Lipo knew, FHP knew. Dr. Lipo knew that Fricano was paid by the slide and moonlighted at other labs (Lipo Dep. p. 86). Because Lipo knew, FHP knew. Dr. Lipo knew his quality assurance in cytology consisted of admonishing Fricano to "read them right" (Lipo Dep. p. 85). Because Lipo knew, FHP knew. Dr. Lipo knew that he was running a Pap Mill and allowed Fricano to exceed workload limitations set by every professional cytology society. Because Lipo knew, FHP knew. Additionally, FHP benefitted from Lipo's abusive practices because the CBC bid and FHP's cost were kept artificially low.

FHP knowingly entrusted its patients' Pap smears to a Pap Mill where a whirling dervish cytotech equated proficiency with personal income.

FHP's inhouse deficiencies mirrored its outhouse deficiencies. Continuity of care was a concept foreign to FHP. Despite Karin's express concerns about post-coital bleeding, Dr. Agoncillo never examined her. Instead a P.A. examined Karin. When the bleeding worsened Dr. Agoncillo followed the dictates of the FHP-Airport capitation agreement and referred Karin to Dr. O'Reilly. Dr. Agoncillo and Dr. O'Reilly never spoke about Karin. No one at FHP knew that Dr. O'Reilly took Karin off birth control pills because of the diagnosis of microglandular hyperplasia. Six months later Dr. Olson renewed Karin's birth control pill prescription without examining Karin, speaking to Karin or knowing that she had been off the pill for diagnostic purposes (K. Smith Dep. p. 42). When Karin's bleeding became

profuse and constant and Dr. Bower decided to refer her, he refused to return Karin to Dr. O'Reilly (K. Smith Dep. p. 54). Instead, the dictates of the FHP-Bluemound capitation agreement caused Dr. Bower to send Karin to Dr. Chambers (Bower Dep. p. 29; Chaillet Dep. p. 113). However, if Dr. Bower had told Dr. Chaillet of Karin's request for referral to Dr. O'Reilly and the reasons, Dr. Chaillet probably would have approved of it (Chaillet Dep. p. 115).

Even more importantly, FHP destroyed the continuity of care it owed Karin and interrupted the diagnostic plan Dr. O'Reilly was implementing. Had FHP referred Karin to Dr. O'Reilly following the abnormal Pap smear of June, 1990, Dr. O'Reilly would have either performed a diagnostic conization or referred Karin to Dr. Hoogerland at that time (O'Reilly Dep. p. 61-62). Instead, Karin came under the care of Dr. Chambers who started his diagnostic workup without important historical information, without knowing an important part of Dr. O'Reilly's prior treatment and ended up wasting valuable time reinventing the wheel.

Plaintiffs' expert, Dr. George Ryan, will be critical of this lack of continuity of care. His criticisms, however, will simply echo those of FHP's medical director. Dr. Chaillet testified that it would be inappropriate for an FHP physician to renew a birth control pill prescription without at least talking to the patient (Chaillet Dep. p. 65). He also criticized Dr. Bower's refusal to return Karin to Dr. O'Reilly (Chaillet Dep. p. 115). FHP's capitation agreement with Dr. O'Reilly required a written consultation report in the file (Chaillet Dep. p. 45, 47). In the absence of such a report outlining Dr. O'Reilly's care and treatment, the referring FHP physician should have called Dr. O'Reilly or asked the patient what was being done (Chaillet Dep. p. 49-60). FHP doctors did neither.

The above conduct, although egregious, pales in comparison to the outrageousness of the bidding process that guaranteed the contract to Dr. Lipo. FHP knew its interests (and that of its members) conflicted with that of Dr. Lipo every time CBC bid on the lab contract. FHP knew it was wrong to favor Dr. Lipo over his competitors. Federal regulations, 42 C.F.R. 1300e-17, mandated that FHP disclose the contract with Dr. Lipo. FHP absented Dr. Lipo from the board meeting whenever it voted on the CBC contract. Dr. Lipo testified that he never received any information on competitors' bids because of the conflict of interest.

Despite this knowledge, FHP violated its duty to its members and engaged in a sham. Bradford admitted telling Dr. Lipo what the bid would have to be for CBC to keep the contract (Bradford Dep. II, p. 69). Bradford admitted telling this to Dr. Lipo with every expectation that Dr. Lipo knew he was being told the low bid of the competition (Bradford Dep. II p. 73). Bradford further admitted that he did not provide Dr. Lipo's competition with such favored treatment (Bradford Dep. II p. 78). Instead, he played it by the book with the competition while he opened the book to Dr. Lipo.

Bradford had no choice but to admit this flagrant violation of competitive bid principles. The documentation produced by Dr. Chaillet (Tab C) tells the tale of 1986, when West Allis Memorial Hospital's bid fell short. On February 5, FHP sent out a Request for Proposal to CBC, West Allis and others (Chaillet Dep. Ex. 5). On March 7, Dr. Lipo bid $0.516 per member per month (Chaillet Dep. Ex. 12). On March 12, West Allis bid $0.43 per member per month (Chaillet Dep. Ex. 11). On May 13, Bradford met with Dr. Lipo to discuss the nature of the services to be offered by Dr. Lipo (Chaillet Dep. Ex. 9). On May 16, Dr. Lipo clarified and amended his bid to $0.43 per member per month (Chaillet Dep. Ex. 8). Mr. Bradford testified that Dr. Lipo's amended bid matched West Allis through pure coincidence (Bradford Dep. II p. 73-74). A jury will view that explanation as pure nonsense.

Under the euphemism of "managed" health care, Family Health Plan equated "quality" of care with "cost" of care. This "cost" approach led it to abdicate its duty to provide quality care to its Plan members. Even more outrageous was the double standard Family Health Plan applied to "cost" when the vendor was a Family Health Plan insider. The subversion of the competitive bid process to insure Dr. Lipo would keep the Family Health Plan contract shows how cost took a back seat to privilege and influence.

Bradford also exposes Lipo as a liar. Lipo testified that he never received any competitive bid information before his bids were finalized (Lipo Dep. p. 132-133). Bradford's testimony establishes to the contrary (Bradford Dep. II p. 69,73).

June Fricano

June Fricano could only exist in the atmosphere created by FHP. Fricano not only violated every known professional guideline for cytotechnologists,

she bragged about it. She valued income so highly she insisted on per slide payment (Lipo Dep. p. 100), worked seven days a week, 51 weeks a year, brought slides home for review (Fricano Dep. p. 72), and reviewed slides for as many as five different labs in the same week (CBC, Columbia, Trinity, Bayshore, Lakeland). While Fricano's blitzkrieg approach to Pap smears was financially rewarding, it inevitably caused unjustifiable misreads.

There is no question that Fricano misread Karin's Pap smears of June 1988 and April 1989. Fricano admitted at her deposition that these two smears were not "negative, Class I" as reported, but rather "suspicious for adenocarcinoma, Class IV" (Fricano Dep. p. 40-41, 45). Plaintiffs' expert cytotechnologist, Gail Borkowski-Klein, concurs that the correct diagnosis of the June 1988 and April 1989 slides is "suspicious glandular cells present, rule-out adenocarcinoma" (Borkowski-Klein Dep. p. 85-86). So obvious are these abnormalities that Fricano testified she probably read both cases as abnormal (implying she had been overruled by Dr. Biller) (Fricano Dep. p. 41, 89-90).

The professional guidelines for workload limitations on Pap smear readings are clear and of long standing. In 1988 and 1989, when Fricano misread Karin's Pap smears, The American Society of Cytology recommended a limitation of 12,000 cases per year (Tab B). The American Society of Cytotechnologists recommended a limitation of 80 slides per day (Tab B). The College of American Pathologists established workload units for Pap smears of five minutes per slide (Tab B). (C.A.P. workload units of "4" were referenced in FHP's 2/86 Request for Proposal.) Borkowski-Klein testified that the Wisconsin State Laboratory of Hygiene limited their cytotechnologists to 39 slides per day and at Dane County Cytology, no cytotechnologist routinely read even 100 slides per day (Borkowski-Klein Dep. p. 107, 186). In 1988, the federal government amended the Clinical Laboratory Improvement Act (CLIA), to incorporate Pap smear workload limits in labs doing Medicare and Medicaid work. The initial limits were 120 slides per 24 hours (80 new slides and 40 rescreens) (42 CFR § 493.1257). Later, CLIA was again amended to place a limit of 100 slides per 24 hours.

Fricano's workload exceeded every guideline, recommendation or limitation ever established. Fricano's excessive, outrageous and reckless workload is well documented.

Dr. Lipo knew Fricano read as many as 200 slides a day for CBC and bragged about reading as many as 30 slides per hour (Lipo Dep. p. 123, 127). Fricano invoices produced by CBC, Bayshore Clinical Laboratory, Trinity Memorial Hospital and Columbia Hospital document that in 1988 and 1989, Fricano was reading in excess of 43,000 cases per year (Tab D) (versus the 12,000 guideline). Since two-slide cases were common practice in 1988 and 1989, Fricano was probably reading in excess of 86,000 slides per year. Assuming she worked seven days a week, 51 weeks per year, that means Fricano read more than 240 slides per day (versus the guidelines of 60, 80, 100 or 120). If Fricano worked eight hours per day, seven days a week, without taking a single break, she would need to <u>average</u> two minutes a slide to keep pace (a pace consistent with her brag of 30 slides per hour). If she worked 16 hours a day, seven days a week, without a break, Fricano would have to <u>average</u> four minutes a slide to keep pace. In either situation, Fricano could not meet the C.A.P workload unit time of five minutes per slide.

These numbers are so staggering and the limits on human concentration so obvious that two conclusions are inescapable: 1) Fricano could not pay attention to every slide she read; and 2) Fricano could not possibly have read every slide she submitted invoices for.

<u>Chem-Bio and Dr. Lipo</u>

Dr. Lipo ran Chem-Bio Corporation in the classic "Pap Mill" manner. Dr. Lipo operated the Pap smear portion of CBC in a manner that mirrors the scandalous abuses detailed in the Wall Street Journal article published in 1987 (Tab E) and read by Dr. Chaillet. Dr. Lipo paid Fricano by the slide thereby creating an economic incentive to put volume ahead of accuracy. He knowingly allowed Fricano to read Pap smears in a volume that is hard to comprehend. Dr. Lipo knew that Fricano was working at the Wilkinson Clinic and Columbia Hospital labs (Lipo Dep. p. 86). While he was unaware of Fricano's work at Bayshore and Trinity, he had no objection to her working at other places because as far as he knew her work was good (Dr. Lipo p. 87). However, the complete lack of standard quality control measures insured Dr. Lipo could stay blissfully in the dark.

Dr. Lipo's quality control for Fricano was to tell his human buzzsaw to "read them right" (Lipo Dep. p. 85). The 10% random rescreening was hardly random. June Fricano had the rescreening log in her desk and under her control (Fricano Dep. p. 61). She inevitably knew that the "random" rescreen would be of every slide ending in "2". Even Fricano could figure out that spending a little more time on those slides would be fruitful.

While 10% random rescreen is now incorporated into CLIA, it is well documented as an ineffective method to catch a cytotechnologist with an unacceptable number of misreads (Borkowski-Klein Dep. p. 109). There are only two instances in five years of a discrepancy between Fricano's CBC interpretations and the CBC rescreens (CBC response to Plaintiffs' RPD). While at Columbia Hospital, there were 13 discrepancies out of 198 slides rescreened (Koenig Dep. Ex. 7). This raises the question of whether CBC ever did the rescreening or whether the CBC pathologists there were as adept at reading Pap smears as they were at reading adenocarcinoma on cervical biopsy.

Dr. Lipo has referred to C.A.P. accreditation as indicative of the quality of the lab he ran. Plaintiffs' experts will explain the inadequacy of C.A.P. respecting cytopathology. However, Dr. Lipo's approach to C.A.P. as it relates to Fricano further illustrates the abdication of his responsibilities as medical director of CBC. Dr. Lipo let Fricano fill out the cytology portion of the C.A.P. application and inspection without any supervision. As he characterized it: "June was fairly unique" (Lipo Dep. p. 71). The "test" cases sent to CBC by C.A.P. were allegedly answered separately by Fricano and the pathologists. The individual answers of Fricano and the pathologists were never kept. Any discrepancy between the answers were reconciled and a consensus answer was returned to C.A.P. (Lipo Dep. p. 78).

Testimony will show that Dr. Lipo/CBC's decision to pay Fricano by the slide, rather than salary, saved Lipo/CBC money. If Dr. Lipo referred the slides out, a review would cost CBC approximately $5.00/slide. If Lipo employed the appropriate number of cytologists to handle the volume of Pap smears within the guidelines, he would need two full time and one half-time positions. Their salaries along with their benefits would have cost Lipo/CBC more than the per slide, no benefits arrangement with Fricano.

CBC's non-existent quality control extended beyond Fricano to the overall cytology operation of the lab. CBC failed to have a standard system requiring that a patient card or comparable device listing all previous tests and results be given to the cytotech or pathologist along with the current slides. Dr. Montag, an expert pathologist, has never worked in a lab without a retrieval system (Montag Dep. p. 95-96). Dr. Koenig and Dr. Molot followed such procedure at Columbia and Lakeland Hospitals. Other experts for the plaintiffs will support that standard. It is incomprehensible that a clinical laboratory would not have a procedure for producing all previous biopsy reports each time a new biopsy was taken.

A meaningful retrieval system was also required for quality assurance purposes. The standard requires rescreening of the patient's prior negative Pap smears when an abnormal Pap or biopsy is diagnosed (Borkowski-Klein Dep. p. 113). This is the surest way to detect past "false negatives" and detect poor cytology work. CBC had no such procedure. Consequently, when Fricano diagnosed the abnormal Pap in June 1990, neither Fricano nor the CBC pathologists were aware of the Paps of June 1988 and April 1989. Presumably, if Fricano can now see the June 1988 and April 1989 smears as "suspicious for adenocarcinoma, Class IV" she would have seen that abnormality on rescreen in June 1990.

CBC also lacked a requirement that a clinical history accompany the biopsy, at least if Dr. Biller and the biopsy reports of June 1989, December 1989, and July 1990, are to be believed (Biller Dep. p. 29-31). Thus, Dr. Molot and Dr. Biller had no idea that Karin's biopsies were occasioned by a history of post-coital bleeding, a symptom not explained by microglandular hyperplasia (Hoogarland Dep. p. 30-31). This most basic of information is standard practice and its absence is inexcusable.

CBC also lacked a continuing education requirement. Neither Fricano nor the pathologist were required to attend seminars or meetings and keep up to date on cytology (Molot Dep.) The impact of this is painfully obvious in Fricano's repeated failure to diagnose HPV as documented by the HCFA inspection of CBC (Borkowski-Klein Ex. 2).

<u>Molot and Biller</u>

The evidence is uncontrovertible that Dr. Molot misread the biopsies of June 1989, and Dr. Biller the biopsies of November 1989 and July 1990. The testimony of Dr. Montag establishes the misses. The slides from June 1989, December 1989, and July 1990, all show the malignant features of: 1) glands infiltrating stroma; 2) nuclear enlargement; 3) variation in nuclear size; 4) irregularly clumped chromatin; 5) prominent nucleoli; 6) clear cytoplasm; 7) hobnail cells; and 8) papillary architecture (Montag Dep. p. 123-127). The biopsy reports themselves described a "papillary architecture" and clear cytoplasm ("mucinous metaplasia") which is characteristic of adenocarcinoma not microglandular hyperplasia (Montag Dep. p. 122). Additionally, Dr. Lipo admitted at his deposition that he didn't know what

the biopsies showed when he read them, but he knew that they were not "garden variety microglandular hyperplasia" (Lipo Dep. p. 32). Dr. Molot admitted that "stromal invasion equals malignancy". The pathologists who remain to be deposed will express opinions as strong as that of Dr. Montag, regardless of whether they have been retained by the plaintiffs or the defendants.

Additionally, Dr. Biller did not request retrieval of the prior tests on Karin in July 1990. Had he done so, he would have known of the two prior biopsies and the abnormal Pap smear from June 1990. This information would require the average, competent pathologist to conduct a cytological/histological correlation and, if done competently, conclude that microglandular hyperplasia was an erroneous diagnosis.

Dr. Chambers

Dr. Chambers' negligence lies in his failure to order either a D & C or conization between July 1990 and December 1990. Dr. Hoogerland testified that Karin's symptom of significant post-coital bleeding could not be explained by microglandular hyperplasia (Hoogerland Dep. p. 30-31). He further testified that microglandular hyperplasia is an incidental finding in Karin's case (Hoogerland Dep. p. 36). Karin's complaint and her abnormal cervical exam required that Dr. Chambers look beyond the pathological diagnosis and perform either a D & C or a conization. Dr. Hoogerland said that "it looked and smelled like cancer" which obligated a doctor to assume it is cancer and persist in performing diagnostic tests until cancer is eliminated (Hoogerland Dep. p. 30, 41).

Dr. Hoogerland's testimony is amply supported by Dr. O'Reilly's plan as well as her testimony. Dr. O'Reilly made it abundantly clear in her deposition that she was implementing a plan to rule out carcinoma. The second biopsy was more extensive and more aggressive than the first (O'Reilly Dep. p. 53). She ordered tests to eliminate a bleeding disorder as an explanation (O'Reilly Dep. p. 57). She took Karin off birth control pills in December 1989 to treat the supposed microglandular hyperplasia (O'Reilly Dep. p. 57). She would not have accepted the pathological diagnosis of microglandular hyperplasia as a sufficient explanation for Karin's post-coital bleeding problems particularly in light of the abnormal Pap smear (O'Reilly Dep. p. 61-62). Had FHP referred Karin to her in 1990 with the history of an abnormal Pap smear, Dr. O'Reilly would have persisted in her diagnostic efforts and either performed a conization procedure or referred Karin to Dr. Hoogerland for a second opinion (O'Reilly Dep. p. 61-62).

That Karin complained of significant post-coital bleeding cannot be denied. The above chronology not only documents the frequency of the bleeding but the fact that it became more pronounced over time. It cannot be denied that Karin's cervix was obviously abnormal on exam. That, too, is documented by the chronology. After he initially examined her cervix, Dr. Chambers told Karin he had never seen anything like it (K. Smith Dep. p. 103). Perhaps most telling is the exam by the "out of plan" OB-GYN, Dr. Stewart. Karin's history and his cervical exam were all he needed to send her immediately to a gynecological oncologist with the working diagnosis of "cancer" (Hoogerland Dep. p. 11).

Chambers was aware of the two indicia requiring him to do more than just repeat a biopsy, take Karin off birth control pills another time and try cryosurgery another time. In short, the standard of care required Dr. Chambers to pick up where Dr. O'Reilly left off rather than waste ten precious months repeating the same procedures.

One must ask how many times an OB-GYN should continue to biopsy the same cervical sites, observe the same cervical vascular abnormalities and take the same history of post-coital bleeding before performing a D & C or conization. One must also ask how many years a woman must bleed, be biopsied and have an abnormal Pap smear before the OB-GYN and the pathologist speak to each other about the accuracy of the working diagnosis. Unfortunately for Karin Smith, the answer is 1989 and 1990, not 1991 when Dr. Stewart and Dr. Hoogerland acted as clinicians are supposed to, and the diagnosis was made.

CAST OF CHARACTERS

Karin Smith - 27 year old victim of three-year delay in diagnosis of cervical cancer.

FHP - Family Health Plan - local Milwaukee HMO.

CBC - Chem-Bio Corporation - clinical lab owned by Dr. Lipo. Interpreted Pap smears and tissue biopsies of FHP members per capitation agreement.

June Fricano - Cytotechnologist reviewing Pap smears for FHP members through Chem-Bio Corporation lab.

Dr. Lipo - owner of CBC and officer and director of FHP.

Dr. Molot - pathologist who worked for CBC and misinterpreted first cervical biopsy.

Dr. Biller - pathologist who worked for CBC and misinterpreted second and third cervical biopsies.

Dr. O'Reilly - first OB-GYN who evaluated Karin for post-coital bleeding.

Dr. Chambers - second OB-GYN who evaluated Karin for post-coital bleeding.

Dr. Olson - FHP employee physician.

Dr. Bower - FHP employee physician.

Testimony of Steven Bosworth
Before the Subcommittee on Labor
Committee on Labor and Human Resources
February 3, 1993

Mr. Ira Magaziner
Senior Policy Advisor to the President for Policy Development
The White House
1600 Pennsylvania Avenue, N. W.
Washington, D.C. 20500

Dear Mr. Magaziner:

I am delighted that the President has chosen to reform the nation's health care system. Hopefully, a consensus will develop that will deal with the many complex issues associated with this problem.

I am sure that you are inundated with suggestions, proposals and advice from all segments of the population. I know that there are dozens of groups vying for attention to elucidate their ideas. This is precisely why I am writing.

You should know that my wife and I have practiced in the health insurance field for well over 10 years. She has worked for one of the largest HMO's in the country and is intimately familiar with the policies of Managed Care organizations. I own an independent brokerage firm, representing a diverse group of employers, including Physicians, in the purchase and management of employee benefit plans, the largest being health insurance. We also happen to be covered by an HMO plan which is my wife's employer.

So, you can see that we have experience and knowledge in the subject of Managed Care. Unfortunately, our experiences have been quite horrifying and our knowledge of the industry has been greatly increased by our experience.

In 1989, my wife discovered a lump in her breast. She immediately made an appointment to see our Primary Care Physician to obtain a referral authorization for a mammogram. He refused, citing her young age (29), even though she had a history of fibrocystic breast disease. Not satisfied with his laissez-faire attitude, we returned a month later to insist on the referral. At this point a new lump had developed under her arm. The doctor told her that she had "lumpy breasts" and a "fatty tumor" under her arm. However, at my insistence, he reluctantly said he would try to obtain the "O.K." from our HMO for the mammogram.

In January, 1990, after a five month wait, the mammogram was approved and performed. When we called for the results, the doctor said that there were no problems. At this point we decided to apply for other health insurance that would allow us more freedom and control over our own lives. We needed to have this doctor put in writing his diagnosis, so that we could obtain the new insurance. He refused to do this until he performed a biopsy. This raised questions, on our part, to the truth of his diagnoses. We obtained the mammogram report and found that there was quite a different story to be told.

At this point, we went out of the HMO "system" at our own expense to obtain a biopsy. Our worst fears were realized when the diagnoses of breast cancer was returned. A week later my 30 year old wife was undergoing surgery to remove the affected breast. After six months of aggressive chemotherapy, we thought that this "thing" was behind us and that we could get on with our lives. However, within a year we found that the cancer had reoccurred this time to her liver and bones. Our only curative hope was for her to have a bone marrow transplant.

When she spoke to her employer about the treatment, they assured her that they would cover the treatment if she wanted it. To our utter amazement and dismay, the HMO instead, tried everything in the "book" to NOT pay for this potentially life saving treatment. They even tried to manipulate our physicians by getting them to say that nothing could be done, that her case was hopeless and that she should go home to die. When we did find that there was hope and that the Bone Marrow Transplant would help our only recourse was to file a lawsuit against the HMO.

Eventually, the HMO did pay for the treatment. It was not expensive as they would have all of us to believe. The total cost was under $75,000., a small price to pay for the health of a young, active, productive mother of a 4 year old child.

We continue to be manipulated by the HMO. They now refuse to allow my wife to be seen by her physician who performed the Bone Marrow Transplant. We will now be forced once again, to go outside the "system" and pay for her check-ups out of our own pocket.

Through the course of these events we have discovered and have proof of, a grand scheme of cover-ups, lies,

manipulation, coercion, collusion and similar scandalous tactics that should be investigated by the highest government authority.

Physicians and other health care providers who serve HMO patients tell of similar experiences of manipulation and coercion on the part of HMO's to limit and/or delay necessary medical care. It is quite noteworthy that these organizations collect our premiums for health care and through a maze of financial incentives, they manage to keep over half of the premiums to add to their ever burgeoning profits. Where is the value to an HMO subscriber who pays over $150. per month for medical care and yet, his or her physician only receives about $40. to provide all care? Why are these organizations allowed to dictate medical care and allowed to practice medicine without a license? Corporations have no right to interfere with the sacred relationship of the physician and patient.

My professional and personal experience with Managed Care is that they claim to contain costs only by denying benefits and services. This point is proven in my wife's case and there is evidence of this in countless case histories. Studies by the Rand Corporation and Congress question the real cost savings of Managed Care plans. I would add that many times these savings are falsely achieved by shifting costs to indemnity or other type health insurance plans, or to individuals who pay cash for their care.

I do not assume to be more knowledgeable than you in your quest for solutions to the health care problem. Through professional and personal experience, I do offer you this advice. No matter what anyone or any organization has told you about Managed Care, do your own investigation. Do not rely on data produced by Managed Care groups, for there is counter data available that will dispute their claims. Look at everything and ask for proof of every claim. Above all, remember that your decisions will ultimately affect the lives of over 200 million people.

I would like the opportunity to meet with you regarding Managed Care, their contracting and financial incentives, denial of benefits and general practices that are detrimental to the health of our country and it's citizens. I am beholden to only the truth.

I look forward to hearing from you.

Sincerely,

Stephen L. Bosworth
President

PROVIDER SERVICES AGREEMENT

THIS AGREEMENT is entered into between [ ]a California corporation, and [redacted] Medical Group, as a Participating Medical Group (PMG) to be effective January 1, 1990.

ARTICLE I

RECITALS

1.01 [ ] is a federally qualified health maintenance organization and a prepaid hospital service plan which is required by law to arrange for health services to be provided to its Members on a prepaid basis.

1.02 PMG is a group of physicians, organized as a legal entity under the laws of the State of California or as an association or partnership, which desires to provide or arrange for the provision of medical services on a prepaid basis to [ ] Members who choose PMG to provide such services.

1.03 PMG shall provide its services at or through its main facility located at [redacted] California [ ] and/or through satellite facilities approved by [ ]. The facilities, Satellites or other locations which are also approved by [ ] and included within the scope and terms of this Agreement, if any, are described in Exhibit D which is attached and incorporated into this Agreement.

ARTICLE II

DEFINITIONS

2.01 Basic Health Services are those services provided in accordance with the Member's Certificate(s) and any additional services required under applicable federal and state laws and regulations governing the operations of [ ]. A list of these services is attached and incorporated into this Agreement as Exhibit A.

2.02 CRVS is the 1974 California Relative Value Studies published by the California Medical Association. The agreed upon conversion factors utilized with the CRVS are set forth in Exhibit B which is attached and incorporated into this Agreement.

2.03 Capitation Services are all [ ] Basic Health Services which are not otherwise defined in this Agreement as Insured Services (Article X) or Shared Risk Services (Article XII) or Reinsured Services (Article XIII). The prepaid amount which PMG receives as compensation for Capitation Services is set forth in Exhibit C which is attached and incorporated into this Agreement.

2.04 Copayment is an additional fee charged to a Member which is approved by the applicable state and federal regulatory authority, and is disclosed and provided for in the Member's Certificate.

2.05 Coverage Certificate or Certificate is the Hospital and Professional Services Certificate and any amendments thereto, issued in connection with the Hospital and Professional Services Agreement between [ ] and an enrolled group or an individual. The Hospital and Professional Services Agreement establishes the services to which Members are entitled. A summary of the benefits of each plan type is set

forth in the [redacted] Participating Medical Group Operations Manual (hereinafter the "Operations Manual").

2.06 Emergency means a sudden, serious, and unexpected illness, injury or condition requiring immediate medical attention.

2.07 Emergency Out-of-Area Services are those emergency services which occur outside of a thirty (30) mile radius of each PMG location or the designated central location for the Independent Practice Association.

2.08 Enrollment Area is that portion of [redacted] service area lying within a thirty (30) mile radius of each PMG location, or the designated central location in the case of an Independent Practice Association, for purposes of membership acceptability at the PMG.

2.09 Family Member is the subscriber's enrolled spouse and/or each enrolled eligible dependent as determined by [redacted] and defined in the Operations Manual.

2.10 Medical Advisory Committee is a committee composed of selected regional representatives from the Medical Directors from each of the PMGs, or their designees, the [redacted] Medical Director, and other appropriate [redacted] staff. The Medical Advisory Committee meets regularly to recommend policies to [redacted] which affect the delivery of health services to [redacted] Members, and to coordinate, as requested, quality assurance, utilization management, and continuing education activity.

2.11 Medically Necessary Services means those covered services provided by a health facility or health professional, and which are:

(a) Appropriate for the symptoms and diagnosis or treatment of a condition, illness or injury; and
(b) Provided for the diagnosis, or the direct care and treatment of the condition, illness or injury; and
(c) In accordance with the standards of good medical practice in the organized medical community; and
(d) Not primarily for the convenience of the Member, or the Member's physician and surgeon or other provider; and
(e) The most appropriate medical service to be provided to the Member. When applied to hospitalization, this also means that the Member requires acute care due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe and adequate care as an outpatient or at a lower utilization level.

2.12 Member is a Subscriber or Family Member.

2.13 Member Physician is a physician or surgeon who practices medicine in the capacity of a shareholder, partner, employee, or associate of PMG on a continuing basis.

2.14 Operations Manual means the [redacted] Participating Medical Group Operations Manual, as amended from time to time, which is incorporated in this Agreement by reference. In the event that any provisions in the Operations Manual or any amendments thereto are inconsistent with the terms of this Agreement, the terms of this Agreement shall prevail.

2.15 Primary Care Physician means the Member Physician responsible for coordinating and controlling the delivery of Covered Services to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians, obstetrician/gynecologists, and may also include other specialists if approved by [redacted]

2.16 Quality Assurance Program means a program approved by [redacted] (under its Quality Assurance and Utilization Management Program) which is designed to assure the provision of quality medical services, as described more fully in the Operations Manual.

2.17 Sponsored Dependent is a dependent of the Subscriber who does not comply with the stated Family Member definition but who will be covered due to a special agreement with [redacted] and the Employer Group.

2.18 Subscriber is the [redacted] Member who has met the membership qualifications, whose enrollment form has been accepted by [redacted] and in whose name the [redacted] identification card is issued.

3.06 In the event [redacted] fails to make payments to PMG under the terms and conditions of this Agreement within the times set forth herein, PMG may terminate this Agreement, but only if [redacted] has failed to make such payments following ten (10) business days prior written notice from PMG. PMG may not terminate this Agreement after giving such notice unless, during the ten (10) business day notice period, the parties have conferred and attempted in good faith to resolve the matter.

3.07 In no event, including but not limited to nonpayment by [redacted] insolvency or a breach of this Agreement, shall any Member be liable for any sums owed by [redacted] and neither PMG nor any physician or other health care provider rendering services to Members pursuant to this Agreement shall bill, charge, collect a deposit or other sum or seek compensation, remuneration or reimbursement from, or maintain any action or have any other recourse against a Member or other person acting on a Member's behalf.

3.08 Neither PMG nor any physician or other health care provider rendering services to Members pursuant to this Agreement shall make any surcharge upon a Member or other person acting on a Member's behalf. If [redacted] receives notice of any surcharge upon a Member, it shall be empowered to take appropriate action. This provision shall not prohibit collection of applicable Copayments as set forth in the Member's Certificate.

3.09 The obligations set forth in Section 3.07 and 3.08 hereof shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed for the benefit of Members, and the provisions of this Section shall supersede any oral or written agreement to the contrary now existing or hereafter entered into between PMG and any Member or any persons acting on their behalf.

3.10 Nothing contained herein shall be construed to limit either party's lawful remedies (including the right to terminate this Agreement) in the event of a material breach of this Agreement.

3.11 Upon termination of this Agreement, PMG agrees to allow the copying and transfer of medical records of each [redacted] Member who has selected PMG to the physician assuming the Member's care at termination. Such copying of records shall be at [redacted] expense. In addition, [redacted] shall continue to have access to records in accordance with Section 4.05 hereof.

2.19 Surcharge is an additional fee which is charged to a Member for a covered service but which is not approved by the applicable state and federal regulatory authority, and is neither disclosed nor provided for in the Member's Certificate.

2.20 Utilization Management Program means a program approved by [redacted] and designed to review and control the utilization of medical services, as described more fully in the Operations Manual.

ARTICLE III

TERM OF AGREEMENT, TERMINATION

3.01 This Agreement shall be in effect for an initial period of twelve (12) months from the effective date set forth above and shall be continued for consecutive annual periods each year thereafter, unless terminated as provided herein.

3.02 If this Agreement is extended pursuant to Section 3.01 hereof, it shall continue on the same terms and conditions herein contained, except as otherwise mutually agreed to by the parties.

3.03 This Agreement may be terminated by either party upon at least ninety (90) days written notice to the other party.

3.04 Should this Agreement be terminated pursuant to Section 3.03, 3.05 or 3.06, PMG agrees to continue to provide services to [redacted] Members who have selected PMG, including any Members who become eligible during the notice period set forth in Section 3.03 above, until the annual anniversary dates of those Certificates then in effect. Such services shall be provided on the same terms and conditions herein contained and at the rates of compensation then in effect under this Agreement.

3.05 Notwithstanding Section 3.04, upon the receipt of notice of termination by either [redacted] or PMG, and in order to assure the continuity and appropriateness of medical care to [redacted] Members, [redacted] at its option, may immediately inform [redacted] Members of such termination notice. Such Members may then be required to select another [redacted] Participating Medical Group prior to the effective date of termination of this Agreement.

3.12 Termination of this Agreement shall not affect any right or obligations hereunder which shall have previously accrued, or shall thereafter arise with respect to any occurrence prior to termination, and such rights and obligations shall continue to be governed by the terms of this Agreement.

ARTICLE IV

GENERAL PROVISIONS

4.01 [redacted] shall provide PMG with an Operations Manual (incorporated herein by reference) which identifies the methods of administration of this Agreement, including grievance procedures, quality assurance programs, utilization reporting procedures, and billing and accounting of services rendered hereunder. Modifications to the Operations Manual will be made by [redacted] and, when possible, shall be sent to PMG for review prior to implementation.

4.02 The maximum capacity for PMG during the terms of this Agreement shall be the number of [redacted] Members set forth in Exhibit D, which is attached and incorporated into this Agreement. [redacted] and PMG shall cooperate with each other to assure that the maximum capacity of PMG for the provision of health services shall not be exceeded. Maximum capacity shall be reduced only upon one hundred eighty (180) days written notice by PMG to [redacted]. However, in the event that PMG materially changes its manner of operation during the term of this Agreement, including, but not limited to the number of Primary Care Physicians available to treat [redacted] Members, [redacted] may suspend any further enrollment of [redacted] Members with PMG

regardless of the stated maximum capacity set forth in this Agreement. PMG shall give [redacted] written notice at least one hundred eighty (180) days prior to the closing of any satellite facility(ies) operated by PMG to which [redacted] Members have been assigned.

4.03 In the event PMG expands its capacity by the addition of new or satellite facilities, it shall provide [redacted] with no less than ninety (90) days prior written notice of the proposed expansion. Within thirty (30) days from receipt of such notice, [redacted] shall either approve or disapprove in writing the use of such new or additional satellite facilities for the purpose of servicing [redacted] Members at such facilities.

4.04 [redacted] shall maintain (or arrange to have maintained) records, and establish and adhere to procedures, as shall reasonably be required to accurately ascertain the number and identity of Subscribers and Family Members who have selected PMG. PMG shall cooperate with [redacted] in connection with such records and procedures administration to the end of enabling the parties to accomplish, with maximum efficiency and minimum administrative cost, prompt determinations of eligibility for coverage and the amount of compensation due to PMG for services it has contracted to provide to [redacted] Members, it being understood that [redacted] determinations as to eligibility of Members are binding on the parties hereto.

4.05 [redacted] shall have the right, upon request, to inspect and copy, at its own expense, upon reasonable advance notice and during normal business hours (or at such other times as may be agreed), Member medical records, relevant accounting and administrative books, and records maintained by PMG as they pertain to this Agreement. PMG agrees to provide [redacted] with copies of Member medical records at PMG's expense upon reasonable request for the purposes of making determinations regarding payment of claims, availability of benefits, and for the conduct of [redacted] Utilization Review, Quality Assurance and Grievance programs. Ownership and access to the medical records of [redacted] Members shall be controlled by applicable state law and this Agreement.

4.06 [redacted] and PMG shall each maintain, in accordance with standard and accepted accounting practices, financial and accounting records relating to services provided or paid for hereunder as shall be necessary and appropriate for the proper administration of this Agreement, the services to be rendered, and payments to be made, hereunder or in connection herewith.

4.07 [redacted] and PMG shall jointly and severally maintain statistical records with respect to the utilization of medical services, hospital services, and other [redacted] covered services, by [redacted] Members, and shall maintain records with respect to any other related matters mutually determined to be necessary or convenient for the proper administration of [redacted] and of this Agreement. At a minimum, PMG agrees to deliver accurate Member encounter data to [redacted] no later than forty- five (45) days following the end of the month in which care was rendered. Such data shall be presented in [redacted] required reporting format as set forth in the PMG Operations Manual and shall include, but not be limited to the following:

a. Patient encounters;
b. Capitated and Insured Services;
c. Frequency of type of care rendered;

d. Referral activity;
e. Laboratory and X-ray services;
f. Utilization of ancillary services;
g. In-area professional emergency care; and
h. Maternity care.

4.08 Information required under this Agreement shall be provided to each party hereto pursuant to procedures designed to protect the confidentiality of patient medical records in accordance with applicable legal requirements, recognized standards of professional practice, and generally accepted procedures followed by Health Maintenance Organizations.

4.09 and PMG respectively acknowledge that the authority and responsibility for coordination of benefits shall be carried out in accordance with Hospital and Professional Service Agreements as reflected in the policies set forth in the Operations Manual.

4.10 In the event that PMG provides services to Members for injuries resulting from the acts of third parties, PMG shall have the right to recover from any settlement, award or recovery from any responsible third party the value of Capitation Services rendered pursuant to the applicable provisions of the Certificate. Further, PMG shall, upon request from , provide with an accounting of all such sums recovered.

4.11 and PMG shall exercise reasonable effort in discouraging changes in a Member's selection of a PMG, except at re-enrollment periods or as otherwise set forth in the Operations Manual. Administration of all transfers of Members shall be responsibility.

4.12 It is specifically understood and agreed by the parties signatory hereto that, to the extent compatible with the rendition of Basic Health Services to Members for which it accepts responsibility hereunder, PMG reserves the right to provide professional services to persons who are not Members. Nothing contained herein shall prevent PMG from participating in any other prepaid health care program. PMG shall provide with notice in advance of any such arrangement along with written assurance that any such commitments to any other prepaid program will not prevent PMG from fulfilling its obligations to Members under this Agreement. Should PMG fail to provide such assurances or should said additional commitments, in the opinion of present a potential adverse effect on PMG's abilities to fulfill its obligations under this Agreement, may suspend further enrollment of Members with PMG.

4.13 and PMG respectively acknowledge that each party will continue to maintain separate and independent management, and that each party has full and complete authority and responsibility with respect to administering its respective organization and operation, insofar as not inconsistent with the respective responsibilities and obligations under this Agreement.

4.14 PMG acknowledges that PMG is not authorized to make nor shall it make any variances, alterations or exceptions to the terms and conditions of the Member's Services Certificates without the express written consent of

4.15 Neither PMG nor [redacted] shall disclose the reimbursement or payment provisions of this Agreement except as may be required by law or as requested of [redacted] by financial institutions.

ARTICLE V

COVENANTS OF PMG

PMG AGREES:

5.01 To participate in quality assurance, utilization management, grievance procedures, and continuing education for medical and management personnel as described in the Operations Manual and to provide information and statistical records to [redacted] as may be reasonably necessary as determined by PMG and [redacted] for the administration of this Agreement and the delivery or covered services hereunder.

5.02 To provide for the availability of [redacted] Basic Health Services at such times, and in such locations within the PMG Enrollment Area as shall be necessary for the prompt and proper rendition thereof, in order to fulfill the obligations assumed pursuant to this Agreement. With regard to the provision of medical services by Member Physicians, there shall be no unreasonable waiting periods for appointments or waiting periods for services for Members once an appointment is kept by the Member. [redacted] shall determine what constitutes an unreasonable waiting period in accordance with applicable state and federal law. In addition, PMG shall ensure the immediate availability of emergency services, 24 hours a day, seven days a week. PMG shall maintain a written telephone log of all emergency service inquiries by [redacted] Members. PMG shall provide [redacted] with sixty (60) days prior written notice of any significant change in PMG's hours of operation or any change in or addition to PMG's current facility location.

5.03 To provide medical social services, patient education, home health care and mental health care or arrange with community agencies to provide such services. In addition, PMG agrees to make referrals to the appropriate organization or agency for acute drug and alcohol abuse, when deemed necessary by PMG, and monitor such referrals.

5.04 To assure that services provided to [redacted] Members shall be provided in the same manner as such services are provided to non-member patients of PMG, except as limited or required by other provisions of this Agreement or by other limitations inherent in the operational considerations of a prepaid health plan, and that, subject to the foregoing, [redacted] Members and prospective members shall not be subject to discrimination on the basis of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, or mental or physical handicap.

5.05 To require each PMG Member Physician rendering services to [redacted] Members to agree to provide, or arrange for the provision of, [redacted] Basic Health Services contracted for by PMG, in accordance with the applicable provisions of this Agreement.

5.06 To make arrangements for rendition of [redacted] Basic Health Services and accept full financial responsibility for Capitation Services when PMG does not, or cannot, provide them directly. PMG shall be cognizant of the quality of care furnished by referral providers.

5.07 To maintain a sufficient number of Primary Care Physicians to guarantee a patient load per physician ratio of not more than 2,000 Members per Primary Care Physician. PMG shall not make the services of Primary Care Physicians available through subcontractual arrangements without the approval of [redacted].

5.08 To assure that PMG physicians and referral physicians shall have hospital privileges which are adequate to meet the requirements for the hospital services to which [redacted] Members are entitled under the terms of their Certificates, or to arrange for the provision of such services by alternative means.

In addition, PMG shall maintain a program to validate the credentials of all PMG Contractors who will provide services to [redacted] Members and to periodically re-evaluate the credentials of all PMG Contractors in accordance with the Operations Manual.

5.09 To ensure that Member Physicians shall be licensed to practice medicine in the State of California. Evidence of such licensure shall be submitted to [redacted] upon request.

5.10 To accept the monthly capitation from [redacted] as payment in full for Capitation Services rendered. PMG agrees not to seek additional payments or compensation from [redacted] Members for Basic Health Services covered under [redacted] Certificates under any circumstances whatsoever. The foregoing restriction shall not apply to copayments, which may be collected by PMG in accordance with the applicable provisions of the [redacted] Certificate, nor to billings and collections on account of noncovered services. PMG shall use its best efforts to advise [redacted] Members of their payment responsibility prior to rendering any service requiring a copayment or any noncovered service. It is understood, however, the PMG's obligation to provide services covered under [redacted] Certificates is independent of any PMG policies related to unpaid bills that a Member may have to PMG for noncovered services provided by PMG.

5.11 PMG shall ensure the timely payment of covered services rendered by referral health professionals. After forty- five (45) days from the date the referral service is billed to PMG, [redacted] at its option, may pay such bill and deduct the appropriate amount from any payment due PMG under this Agreement.

PMG shall, within ten (10) business days of receipt of a request, provide [redacted] with a comprehensive list of incurred and unpaid claims for covered services rendered by PMG Contractors.

5.12 To engage the referral services of only appropriately licensed and certified consultants, specialists and agencies and only as shall be necessary and appropriate (as determined by the appropriate Member Physician) for the purpose of delivery of [redacted] Basic Health Services to [redacted] Members. Nothing in this Agreement shall be construed to permit PMG to subcontract or delegate its duties hereunder without prior approval of [redacted] PMG shall pay referral Health Professionals for Capitation Services rendered and obtain appropriate patient encounter data from such professionals as may be needed to meet the requirements of this Agreement.

5.13 Upon entering into any arrangements with Health Professionals (PMG Contractors) as may be necessary to fulfill PMG's obligations to provide or arrange for the provision of Capitation Services under this Agreement, PMG shall obtain written contracts with such Professionals which abide by the following requirements:

(1) Secure adherence by PMG Contractors to all the obligations of this Agreement which affect them, including but not limited to:

(a) Accepting [redacted] Patients upon referral from PMG Member Physicians;

(b) Accepting payment from PMG for Capitation Services rendered to [redacted] Members referred to them as payment in full, except for authorized copayments, and agreeing not to bill [redacted] or [redacted] Members for such services regardless of whether or not payment is received from PMG.

(c) Hospitalizing [redacted] Members only with authorization of the PMG pursuant to the applicable provisions of this Agreement and the Operations Manual.

(d) Conforming to the drug dispensing guidelines set forth in the [redacted] Drug Formulary.

(e) Maintaining in force adequate professional liability insurance in conformity with the limits described in Paragraph 5.26.

(f) Conforming to all state and federal requirements regarding retention of and access to records, and submission of reports.

(2) To take all reasonable and prudent steps to ensure that all PMG Contractors provide adequate personnel and facilities in order to perform the duties and responsibilities associated with the proper administration of the Agreement, including but not limited to ensuring that:

(a) All facilities utilized by PMG Contractors shall satisfy the standards for licensure and certification, if applicable, by the appropriate governmental licensing agency as well as applicable federal law.

(b) The PMG Contractor assumes the responsibility for supervision of all personnel associated with the PMG Contractor.

(3) Provide assurances that PMG Contractors are complying with all legal standards for quality of care in [redacted] Service Area.

(4) Require that PMG Contractors maintain offices for the provision of health care in locations which conform to [redacted] standards for accessibility of services to [redacted] Members.

5.14 PMG contracts with other health professionals shall be subject to [redacted] review and approval as to conformity with applicable state and federal laws and the requirements of this Agreement.

5.15 To report to [redacted] on a monthly basis, the Capitation Services and Insured Services rendered to [redacted] Members, in the manner and format set forth in the Operations Manual, it being understood that timely payment to PMG is contingent upon PMG's submission of complete documentation required under the Operations Manual.

5.16 To report on a monthly basis, the nature and extent of all coordination of benefits recoveries for professional services rendered by PMG under this Agreement. Such coordination shall be carried out in accordance with the pertinent Subscriber Certificate as reflected in [redacted] policies set forth in the Operations Manual.

5.17 To refer all administrative disputes over covered benefits or services hereunder to [redacted] at the earliest reasonable time for determination, processing and resolution.

5.18 To provide a Coordinator(s) at each numbered facility who shall be responsible for coordinating PMG's participation in [redacted] Grievance Procedure, Medical Social Services Program, and other similar programs mutually agreed upon, which may be implemented from time to time. Coordinators shall periodically participate in [redacted] education programs as requested by [redacted]

5.19 To be cognizant of, and abide by all operating procedures and policies set forth in the Operations Manual and [redacted] Drug Formulary and any amendments thereto, provided to the PMG by [redacted]

5.20 To orient [redacted] Members about the PMG facilities and proper use of the [redacted] program.

5.21 To accept any and all [redacted] Members who select PMG, until such time as PMG reaches its maximum capacity set forth in Exhibit D. PMG shall notify [redacted] in writing one hundred eighty (180) days prior to the date on which it anticipates ceasing enrollment.

5.22 To accept enrollment of any [redacted] Member who is being transferred from another PMG, at the request of that PMG or [redacted] as defined in the Operations Manual.

5.23 To abide by the termination procedures outlined in the Operations Manual when requesting termination of a [redacted] Member by [redacted] PMG shall not request, demand, require or otherwise seek, directly or indirectly, the removal of any [redacted] Member based on that Member's need for, or utilization of, medically required services. PMG may request that [redacted] terminate coverage of any [redacted] Member because of fraud, disruption of medical services, or repeated failure to make required copayments; however, PMG agrees [redacted] shall have sole and ultimate authority to terminate any Member's coverage.

5.24 To work in coordination with [redacted] in efforts to maximize the utilization of allied health professionals and other innovative methods of delivering services that will promote the efficient, economical delivery of care and to participate in development and implementation of programs of health education and health maintenance for [redacted] Members; provided, however, that Member Physicians shall be actively engaged in the supervision of such allied health professionals and the coordination of the Member's care as required by applicable law, regulations and [redacted] policies.

5.25 To obtain [redacted] prior approval for any advertising using the [redacted] name and logo or [redacted] name and for all literature of a general nature intended for [redacted] Members.

5.26 To maintain appropriate insurance programs or policies as follows:

A. Professional Liability Insurance. PMG agrees to maintain Professional Liability Insurance, or other risk protection program, acceptable to [redacted] Notification to [redacted] by PMG of cancellation or material modification of the risk protection program shall be made to [redacted] at least thirty (30) days prior to any cancellation. Certificates of Coverage or documents evidencing Professional Liability Insurance or other risk protection required under this subsection shall be provided to [redacted] upon request.

The coverage to be provided under this subsection shall be in minimum amounts of $1.0 million per claim and $3.0 million annual

aggregate, and, where possible, shall name [redacted] as an additional insured.

B. General Liability Insurance. In addition to Subsection A. above, PMG shall also maintain a policy or program of comprehensive general liability insurance (or other risk protection) with minimum coverage including no less than Fifty Thousand Dollars ($50,000.00) for PMG's property, together with a Combined Single Limit Body Injury and Property Damage Insurance of not less than Three Hundred Thousand Dollars ($300,000.00).

C. Workers' Compensation. PMG's employees shall be covered by Workers' Compensation Insurance in an amount and form meeting all requirements of applicable provisions of the California Labor Code.

5.27 To select Member Physician(s) to function in a liaison capacity with [redacted] and serve, if necessary, on the [redacted] Medical Advisory Committee or any specified committee charged with coordinating [redacted] Quality Assurance, Utilization Management, and continuing education activity when requested by said committee.

5.28 To actively participate in a [redacted] Quality Assurance and Utilization Management Program approved by a [redacted] Medical Director, or designee, or an officer of [redacted] Such program shall be designed in a manner to effect the following:

1. Stress health outcomes to the extent consistent with the state of the art;
2. Provide review by Member Physicians of the process followed in the provision of health services;
3. Utilize systematic data collection of performance and patient results, provide interpretation of such data to the practitioners, and institute needed change;
4. Include procedures for taking appropriate remedial action whenever it is determined that inappropriate or substandard services have been provided or that services which should have been furnished have not been provided;
5. Implement an effective program of preadmission certification for all elective hospital admissions of [redacted] Members.

PMG agrees that a member of [redacted] Utilization Review and Quality Assurance Medical Staff may, as deemed necessary by [redacted] participate in PMG's Quality Assurance and Utilization meetings. In addition, PMG shall provide [redacted] with copies of the minutes of such meetings within ten (10) business days of receipt of a written request for same from [redacted]

5.29 That [redacted] Medical Director or designated representative may be involved in the management of catastrophic cases. PMG will assist [redacted] Medical Director by providing information that may be required in the transfer of a Member into medical facilities designated by [redacted] for the care of catastrophic cases including, but not limited to, prompt notification of known or suspected catastrophic cases. Detailed procedures for Catastrophic Case Management shall be set forth in the Operations Manual.

5.30 To actively cooperate with Case Management individuals designated by [redacted] at the earliest opportunity by providing information regarding catastrophic, transplant, out-of-area, and such other cases where case management is deemed necessary and appropriate by [redacted] Medical Director or designated representative. Such cooperation shall, where reasonably possible, include utilization of all preferred provider and exclusive provider contract arrangements which may be established by [redacted]

5.31 To abide by standards established or approved by [redacted] Quality Assurance Committee in determining appropriate lengths of stay for hospitalized [redacted] Members or appropriate utilization patterns for referral to specialty services.

5.32 To actively participate in the [redacted] program by providing quality health promotion and disease prevention programs to [redacted] Members in a manner which meets specified criteria outlined in the Operations Manual. Such program shall be designed in a manner to effectuate the following:

a. Stress healthy lifestyles to minimize health risk factors and maximize health potential.
b. Focus on patient education as a part of the medical treatment plan directed by physicians.
c. Utilize an integrated and systematic approach to planning, implementing, and evaluating programs including a physician advisory committee and data collection of program usage and results.
d. Delegate responsibility for the program to an interested and qualified health care professional who will coordinate the program for the PMG and act as liaison to [redacted]

5.33 To utilize the data and statistics provided by [redacted] as a reference in determining appropriate lengths of stay for hospitalized [redacted] patients.

5.34 To participate in the review of various accreditation surveys and network-wide studies, and to recommend to the Board of Directors of [redacted], possible participation in individual surveys.

5.35 To maintain all required state and federal certifications, and comply with all applicable requirements of municipal, state and federal authorities, all municipal ordinances and regulations, and all state and federal statutes and regulations now or hereafter in force and effect, which bear directly or indirectly upon the subject matter hereof.

5.36 To permit the Medical Director of [redacted], an officer of [redacted] or designee, and/or any governmental agency having jurisdiction over [redacted] to inspect the premises and equipment of PMG and review all operational phases of the medical services provided to [redacted] Members, including access to medical records of PMG to the extent permitted by law.

5.37 To maintain such records and provide such information to [redacted] and to applicable state and federal regulatory agencies as may be necessary for compliance by [redacted] with the provisions of applicable state and federal law, and shall retain all such records for at least five (5) years. PMG's obligations to retain records and provide information hereunder shall not terminate upon the termination of this Agreement, whether by rescission or otherwise.

ARTICLE VI

COVENANTS OF [redacted]

[redacted] agrees:

6.01 To notify and consult with PMG with respect to the development of any changes or amendments to the extent consistent with [redacted] administrative and competitive requirements. Capitation payments hereunder shall be adjusted in a manner acceptable to [redacted] and PMG, to reflect any additional services which may be required from PMG due to any amendment or change in [redacted] Member benefits.

6.02 To accept sole responsibility for filing reports, obtaining approvals, and complying with the applicable laws and regulations of state, federal, and other regulatory agencies having jurisdiction over [redacted] provided, however, that PMG agrees to cooperate in providing [redacted] with any information and assistance reasonably required in connection therewith.

6.03 To perform, or have performed, all necessary administrative, accounting, enrollment, and other functions appropriate for marketing and administration of the [redacted] program reflected by this Agreement. Any change in such arrangements will be communicated to PMG.

6.04 To abide by a policy whereby nothing contained in this Agreement is intended, or shall be construed, to interfere with the professional relationship between any [redacted] Member and his or her [redacted] Member Physician(s). Member Physicians shall be responsible for maintaining the physician-patient relationship with [redacted] Members and are solely responsible to such Members for all medical services provided.

6.05 To collect, or arrange to have collected, all dues, Subscriber and/or Member payments, and other items of income to which [redacted] is entitled under its employer group and Subscriber Agreements, or otherwise, except for copayments and payments for noncovered services and coordination of benefits for professional services which may be collected by PMG in accordance with relevant provisions of [redacted] Certificates.

6.06 To provide to PMG utilization reports reflecting Capitation Services provided by PMG and reported to [redacted] through the encounter data program within forty-five (45) days of submission of data by PMG.

6.07 To make available to PMG on a voluntary basis, trained personnel to assist PMG in the conduct of preadmission, medical review and concurrent medical review of institutionalized [redacted] Members.

6.08 To notify PMG as soon as the need is known of any contracts between [redacted] and employers, government agencies, or any other groups for care of [redacted] Members, which have terms in excess of twelve (12) consecutive months.

6.09 To undertake reasonable effort in accordance with a standard of good faith, to assure that [redacted] Subscribers assigned to PMG will work or live within the Enrollment Area defined in this Agreement.

6.10 To provide and compensate for acceptable health education/wellness components as appropriate for PMG membership size in accordance with the requirements outlined in the PMG Operations Manual.

6.11 To maintain appropriate insurance programs or policies including a policy of bodily injury and personal injury coverage which includes committee persons as insureds by definition. In the event that policy is terminated or the coverage of committee persons is materially changed, shall so notify PMG and thereupon the Medical Director or designee of PMG may resign from the Medical Advisory Committee.

ARTICLE VII

ELIGIBILITY LISTING

7.01 Eligibility listings of Members who have selected PMG shall be provided to PMG. shall maintain, update and distribute monthly, Member eligibility reports for each month in which the persons included on such list will be eligible for Basic Health Services.

7.02 will attempt to discourage retroactive cancellation of any Member by any employer group after the applicable monthly billing is reconciled. However, where no services have been rendered, may make exceptions due to legitimate administrative processing requirements.

7.03 will attempt to discourage any group from retroactively adding any Member after the applicable monthly billing is reconciled. Only unavoidable administrative errors by the group or its agent may form a basis for retroactively adding any new Member after the monthly billing has been reconciled. may make exceptions for groups which pay a super-composite rate or when a newly eligible dependent must be added to an existing family contract. In the event finds it necessary to retroactively assign a new Member to PMG, capitation payment for that Member shall be made and PMG agrees to be responsible for all services due such Member under the terms of this Agreement, from the date the Member became eligible.

7.04 Retroactive cancellations made pursuant to Section 7.02 will not exceed ninety (90) days. Retroactive capitation adjustments shall be made for any additions or cancellations made pursuant to Sections 7.02, 7.03 and this Section, 7.04.

7.05 In the event care is provided to an ineligible person, based on an erroneous or delayed eligibility list or verbal confirmation of eligibility of said individual by shall be financially responsible for all care provided by PMG prior to the time PMG received notice of that person's ineligibility; provided, however, PMG supplies with evidence that it has unsuccessfully sought payment for all or a portion of such charges from the patient or the person having legal responsibility for such patient, through two billing cycles. In that event, responsibility shall be measured by the CRVS conversion factors described in Exhibit B which is incorporated into this Agreement. Responsibility of under this section shall be subject to the exercise of prudent judgment by PMG evidenced by for verification of eligibility of each Member prior to institutionalizing that Member. In no event, however, shall PMG be financially responsible for services rendered to any person who was not eligible for benefits as determined by except when PMG has failed to make the reasonable efforts described above for verification of eligibility. In the event payment is made to PMG by pursuant to this Section, PMG shall have no further right to and shall not attempt to collect any additional payment from the patient for said services.

ARTICLE VIII

APPOINTMENT OF MEMBER PHYSICIANS BY PMG

8.01 PMG shall be responsible for the selection of Member Physicians, or referral physicians and surgeons who will provide covered services to [redacted] Members. Selection of physicians shall be made by PMG on an individual basis, with reference to reasonable requirements, medical groups procedures, and applicable considerations set forth in Article V. PMG agrees to consider the goal of efficient, effective delivery of services in the course of selecting each physician, and recognizes that the selection of that physician has an impact on the achievement of that goal. In this regard, PMG shall encourage each [redacted] Member to select a Member Physician who is a primary care physician (internist, family practice, pediatrician or obstetrician-gynecologist) and who shall be responsible for the overall coordination of the Member's health care. The appointed physician shall be responsible for the continuity of care provided to each [redacted] Member assigned to him or her pursuant to this Agreement.

8.02 PMG shall provide written documentation regarding Member Physicians to [redacted] on an annual basis or at such other times as may be reasonably requested on a form approved by [redacted] Any changes, additions or deletions to this documentation shall be provided to [redacted] within thirty (30) days of the change.

8.03 PMG agrees to promptly notify [redacted] of action taken by PMG or any hospitals which results in restrictions on a Member Physician's or a referral physician's staff privileges, membership, referral utilization or employment for a medical disciplinary cause or reason as defined in Business & Professions Code 805, regardless of the duration of the restriction. PMG shall further promptly notify [redacted] of the filing of any reports pursuant to Business & Professions Code 805 relating to a Member Physician or a referral physician.

ARTICLE IX

COMPENSATION TO PMG INCLUDING CAPITATION

9.01 Compensation to PMG for Capitation Services shall be a fixed monthly prepayment referred to as "Capitation". Capitation shall be determined in accordance with [redacted] standard rating formula. Such rating formula shall be consistent with those factors established under state and federal regulation. (The rating formula takes into account the factors permitted by the regulations of the Department of Health and Human Services.) The applicable monthly capitation amount for each Subscriber contract designated by [redacted] to be serviced by PMG is set forth in Exhibit C which is incorporated into this Agreement. In the event a Member is not eligible to receive services during the entire month, the capitation payment for that member-month shall be prorated to the number of days the Member will be eligible.

9.02 Capitation shall be paid in consideration for providing availability of Basic Health Services under this Agreement to each [redacted] Member assigned to PMG, and the same shall be in consideration for all capitation services actually rendered, or arranged for, by PMG. The monthly payment shall be made by the tenth of each month and shall be computed on the basis of the most current group information available. A Reimbursement Summary will accompany each check, and where applicable, will identify the employer group, the Subscribers and Family Members who are eligible for covered services, and the amount payable.

9.03 In consideration of PMG offering a approved Program to Members, shall pay PMG a percentage of capitation per month, as set forth in Exhibit D, so long as PMG continues to meet criteria as set forth in the PMG Operations Manual. Such payments shall cease upon thirty (30) days written notice from that PMG no longer meets criteria for participation or should decide to terminate the health education incentive program in its entirety. In the event PMG ceases to meet criteria for the Program, payments made to PMG pursuant to this section shall be subject to retroactive adjustment to the first date of non-compliance with the Program criteria.

9.04 Within seventy (70) days after the end of each month, total payments made will be reconciled against actual payments due, and an appropriate adjustment of overpayments or underpayments will be made. In the event of termination of this Agreement, final settlement of all programs shall be made within one hundred eighty (180) days from the effective date of termination of the Agreement.

9.05 PMG agrees not to charge any Member more in copayments for any service provided outside PMG than the actual cost to PMG of providing those services.

9.06 PMG agrees to continue to provide services and benefits to any Member or former Member who is or becomes eligible for coverage under the Extension of Benefits provisions of the Member Certificate, in exchange for the current single Member capitation amount for the plan type under which the Member is, or was, enrolled.

PMG agrees to cooperate with by taking reasonable steps to determine if another carrier was involved and to notify of the existence of such carrier in accordance with procedures established by and published in the Operations Manual pertaining to benefits for total disability.

In addition, PMG agrees to provide services and benefits for any Member who is totally disabled at the original date of the Member's coverage. In the event payment for such professional services rendered by PMG is obtained by from a prior carrier as an extension of benefits, shall reimburse PMG to the extent of payment received from the prior carrier.

ARTICLE X

INSURED SERVICES

10.01 A special pool of money, called the Transplant Pool, shall be established to cover the cost of Organ Transplants on a network wide basis. The Transplant Pool shall be created as specified in Exhibit D and will be administered according to the guidelines set forth in the PMG Operations Manual.

10.02 A special pool of money, called the AIDS Pool, shall be established for the purpose of payment of expenses incurred in the treatment of diagnosed Acquired Immune Deficiency Syndrome (AIDS) patients on a network wide basis. The AIDS Pool shall be created as specified in Exhibit D and will be administered according to the guidelines set forth in the PMG Operations Manual.

10.03 Additional services may be designated "Insured Services" by agreement between [redacted] and PMG, if permissible under applicable requirements of 42 U.S.C. 300(e) and the regulations pursuant thereto. Refer to Exhibit D. Such professional services shall be provided and paid for by PMG and reimbursable by [redacted] as Insured Services when covered under an applicable Certificate.

10.04 [redacted] will reimburse PMG for Insured Services provided and paid for by PMG within thirty (30) days of receipt of claim, based upon procedures set forth in the Operations Manual and Exhibit D. In the event a claim for reimbursement of an Insured Service is not submitted to [redacted] within sixty (60) days of the date the Insured Service is provided or arranged for, [redacted] may, at its sole discretion, deny reimbursement for said service, in which case the PMG shall have full responsibility for the service.

ARTICLE XI

ENROLLMENT PROTECTION

[PMG'S PARTICIPATION IN THE ENROLLMENT PROTECTION PROGRAM IS OPTIONAL. THEREFORE, THIS ARTICLE XI. SHALL ONLY APPLY IF THE PMG HAS ELECTED TO PARTICIPATE IN THE ENROLLMENT PROTECTION PROGRAM, AND HAS COMMUNICATED SUCH INTENTION BY SEPARATE SIGNATURE ON EXHIBIT D.]

11.01 Enrollment Protection is designed to limit PMG's liability for providing Capitation Services to [redacted] Members during each calendar year.

11.02 PMG's participation in the Enrollment Protection program is optional. If PMG elects to participate in the Enrollment Protection program, the liability of PMG for Capitation Services rendered to any [redacted] Member during each calendar year shall be limited to the amount set forth in Exhibit D as PMG's Enrollment Protection Level.

11.03 The basis for calculation of expenses incurred in reaching the Enrollment Protection Level set forth herein shall be the 1974 California Relative Value Studies (CRVS) figure multiplied by the CRVS conversion factors mutually agreed to by PMG and [redacted] and set forth in Exhibit B, or billed charges, or the actual cost to the PMG, whichever is less.

11.04 Expenses for services rendered in connection with Workers' Compensation cases, or any other case where payments for Capitation Services or Insured Services are obtained from third-party sources or from copayments, shall not be included in expenses incurred in reaching the Enrollment Protection Level.

11.05 PMG shall maintain records necessary to substantiate the attainment of Enrollment Protection Levels. After reaching the Enrollment Protection Level for any [redacted] Member, during the remainder of the calendar year, PMG shall bill [redacted] for one hundred percent (100%) of services rendered, or provided, to that Member by PMG calculated in accordance with Section 11.03, or billed charges, or actual PMG costs, whichever is less. Reimbursement to PMG for Enrollment Protection shall be seventy-five percent (75%) of all charges calculated in accordance with Section 11.03 hereof. Reimbursement to PMG for Enrollment Protection shall be made by [redacted] on a monthly basis, within thirty (30) days of submission of complete documentation by PMG in a format acceptable to [redacted] except for submission in

the month of December, which will be paid within sixty (60) days, or by any other mutually agreed upon method as set forth in the Operations Manual.

11.06 Payment to PMG pursuant to this Article shall be made only if PMG submits all necessary documentation to on or before the expiration of sixty (60) days following the close of the last quarter of the Enrollment Protection period in question.

ARTICLE XII

SHARED RISK SERVICES

12.01 Shared Risk Services, as defined in this Article, shall include the following Basic Health Services authorized or referred by PMG, except when such services are rendered to Members who are enrolled in Parts A and/or B of Medicare and are receiving a discounted premium, or who are receiving services or benefits under the Extension of Benefits provision of the applicable Certificate(s) or non-referred services rendered outside the PMG service area. Shared Risk Services shall include:

A. Inpatient Hospital Services. Institutional charges for inpatient hospital days of care covered under the applicable Certificates for semiprivate room accommodations or special treatment units (or private room accommodations if specifically authorized as medically necessary by a Member Physician).

B. Outpatient Surgery. Institutional charges (excluding physician charges) for outpatient surgery, but only if such surgery is performed in a contracting facility.

C. Emergency Room Services. Institutional charges (excluding physician charges) for emergency room services provided within a thirty (30) mile radius of the selected PMG, or the designated 30 mile area for the selected Independent Practice Association.

D. Related Hospital Services. (1) Institutional charges for related hospital services rendered as a part of, and concurrent with, Subsections A and B above, including the use of hospital equipment, surgical and anesthetic supplies, oxygen and drugs or medications (except take-home drugs), blood and blood processing, laboratory procedures and X-ray examinations billed by the hospital; (2) Professional charges for laboratory procedures and X-ray examinations rendered as a part of and concurrent with Subsections A, B and C above when billed by the hospital or a professional; (3) Prosthetic devices.

E. Skilled Nursing Facility Care. Skilled Nursing Facility care services including the same services as described in Subsections A and D above.

F. Ambulance Service. Ambulance services authorized by the PMG, including air transportation when medically necessary except for such ambulance services rendered in connection with Emergency Out- of-Area Services.

G. Home IV Therapy. When provided through a contracting provider which is Medicare certified or J.C.A.H.O. certified.

H. Home Health Services. Services rendered by a Home Health Agency licensed by the state and certified by the Medicare Program under Part A of Medicare which fulfill criteria in the Operations Manual.

I. Outpatient Substance Abuse Rehabilitation. Professional and institutional charges for services rendered as part of a formal outpatient program.

J. Hemodialysis Services. Institutional and professional charges for hemodialysis services rendered prior to the [redacted] Member's eligibility for Medicare.

K. Chemotherapy. Chemotherapy drugs (FDA approved and used in the treatment of cancer) and professional services related thereto which are not rendered in a hospital facility. Drug costs will be reimbursed at the average wholesale price (AWP) of the drug as defined by the MediSpan Hospital Pricing Guide or the Redbook (whichever is less) for the date of service.

L. Infant Apnea Monitor. The cost of an infant apnea monitor provided to [redacted] Members shall be reimbursed at billed charges or cost whichever is lower, provided, however, that the use of the apnea monitor must be authorized by a Member Physician for use in the home.

M. Hospice. Services must be rendered by an agency approved under Part A of Medicare and provided in accordance with the criteria set forth in the Operations Manual.

N. Injectable Medications. Human Growth Hormone and antihemophilic products (Factor VIII and Factor IX) when furnished by a [redacted] contracting provider.

O. Durable Medical Appliances and Prosthetic Devices. Durable medical appliances and prosthetic devices provided to [redacted] Members shall be reimbursed at reasonable charges, provided, however, [redacted] shall determine whether durable medical appliances shall be purchased or leased.

P. Pre-Existing Pregnancy. Maternity services rendered by PMG to a [redacted] Member who conceived prior to the time of initial enrollment in [redacted] as determined by [redacted] and who is enrolled with PMG at the date of delivery, shall be compensated at Eight Hundred Dollars ($800.00) per applicable Member.

Q. Other Shared Risk Services. Other Shared Risk Services may be established by mutual agreement between [redacted] and PMG and may be incorporated herein by amendment.

12.02 A portion of the premium dues for [redacted] Members assigned to PMG shall be designated as Gross Shared Risk Revenue. The Gross Shared Risk Revenue shall be established based upon the anticipated cost of all Shared Risk Services. The Gross Shared Risk Revenue per Member per month for the PMG shall be as set forth in Exhibit D.

12.03 At the end of the calendar year, the cost of [redacted] reinsurance for PMG, as set forth on Exhibit D, shall be deducted from the Gross Shared Risk Revenue and the amount remaining shall be designated Shared Risk Revenue. The Shared Risk Revenue is available for payment of the Shared Risk Services set forth in Section 12.01.

12.04 Shared Risk Claims credited against Shared Risk Revenue for any one [redacted] Member per calendar year shall not exceed the amount set forth in Exhibit D.

12.05 In the event that claims for Shared Risk Services utilized by Members assigned to PMG exceed the amount of Shared Risk Revenue in any calendar year, [redacted] and PMG shall share equally the excess cost up to the point when total costs exceed Shared Risk Revenue by a percent designated in Exhibit D. (PMG's liability for such excess cost shall not exceed a percent of Shared Risk Revenue as designated in Exhibit D.)

12.06 Any amount still owing for Shared Risk Services after Shared Risk Revenue has been exhausted, and after PMG has paid any additional amount owing by them, shall be the liability of [redacted].

12.07 In the event that claims for Shared Risk Services for any calendar year total less than the amount of Shared Risk Revenue, [redacted] and PMG shall share the surplus up to a percent of Shared Risk Revenue as designated in Exhibit D. PMG shall be entitled to a maximum surplus not to exceed a percent of Shared Risk Revenue as designated in Exhibit D. In the event such costs are less than Shared Risk Revenue for six consecutive months, [redacted] will make an interim payment of seventy-five percent (75%) of such six-month calculation.

12.08 Any surplus Shared Risk Revenue after disbursement of PMG's share (referred to in Section 12.07) shall inure to [redacted].

12.09 Settlement will be on the basis of both paid and incurred claims costs during the calendar year, for Shared Risk Services identified in Section 12.01 and will be made on a final basis within one hundred twenty (120) days of the close of the calendar year. Any claims received after final settlement calculation will be charged to the following year's Shared Risk experience or, in the event of termination of this Agreement, directed to the applicable party for payment based on the previous year's experience.

A. Payment to PMG by [redacted] for any surplus due, or payment by the PMG to [redacted] for any deficit due, shall occur within thirty (30) days following the date of the final Shared Risk Settlement Report, subject to interest of ten percent (10%) annual interest on unpaid balances thereafter. By mutual agreement, [redacted] may deduct any deficits due from PMG from monthly capitation due to PMG, but not to exceed ten percent (10%) of the total capitation. Such deductions shall also include interest at the rate of ten percent (10%) per annum on the unpaid balance.

B. [redacted] shall provide PMG with reports of individual payments and overall claims experience applicable to the determination of payments to be made under this Article, on a monthly basis, within sixty (60) days following month's end. [redacted] shall also provide PMG with Shared Risk Status Reports showing estimated settlement on a semiannual basis within ninety (90) days following the end of the six-month period.

ARTICLE XIII

REINSURED SERVICES

13.01 Reinsured Services, as defined in this Agreement, shall include the following [redacted] Basic Health Services set forth in the Certificate(s):

A. Emergency Out-of-Area hospital and professional services shall be compensated at billed charges.

B. Shared Risk Services. Shared Risk Services utilized by any individual [redacted] Member in excess of amounts to be credited against Shared Risk Revenue as set forth in Article XII and Exhibit D.

13.02 [redacted] shall be liable for the cost of all Reinsured Services under this Agreement and PMG shall not bill or attempt to collect for Reinsured Services from the Member.

13.03 Reinsured Services shall be paid on an incurred basis, as outlined in the Operations Manual.

ARTICLE XIV

ARBITRATION OF DISPUTES BETWEEN

AND PMG

14.01 If the parties to this Agreement cannot settle grievances or disputes between them in an informal and expeditious fashion, the dispute shall be submitted, upon the motion of either party, to arbitration under the appropriate rules of the American Arbitration Association (AAA). All such arbitration proceedings shall be administered by the AAA; however, the arbitrator shall be bound by applicable state and federal law, and shall issue a written opinion setting forth findings of fact and conclusions of law. The parties agree that the decision of the arbitrator shall be final and binding as to each of them. The party against whom the award is rendered shall pay any monetary award and/or comply with any other order of the arbitrator within sixty (60) days of the entry of judgment on the award, or take an appeal pursuant to the provisions of the California Civil Code.

14.02 In all cases submitted to AAA, the parties agree to share equally the AAA administrative fee as well as the arbitrator's fee, if any, unless otherwise assessed by the arbitrator. The administrative fees shall be advanced by the initiating party subject to final apportionment by the arbitrator in the award.

14.03 The parties agree that the arbitrator's award may be enforced in any court having jurisdiction thereof by the filing of a petition to enforce said award. Costs of filing may be recovered by the party which initiates such action to have an award enforced.

14.04 Should the parties, prior to submitting a dispute to arbitration, desire to utilize other impartial dispute settlement techniques such as mediation or fact-finding, a joint request for such services may be made to the AAA, or the parties may initiate such other procedures as they may mutually agree upon at such time.

14.05 Nothing contained herein is intended to create, nor shall it be construed to create, any right of any [redacted] Member to independently initiate the arbitration procedure established in this Article. Further, nothing contained herein is intended to require arbitration of dispute regarding professional negligence between the Member and the PMG.

ARTICLE XV

MEMBER GRIEVANCE PROCEDURE

15.01 shall have primary responsibility for establishing and administering the Member grievance procedure described in the Operations Manual.

15.02 PMG agrees to cooperate in resolving all grievances relating to the provision of medical services to Members in accordance with the grievance procedures established by

15.03 PMG agrees to participate in and provide assistance and information at no cost or expense to as may be necessary or helpful to in administering the above-referenced grievance procedure and in reviewing and evaluating Member grievances presented for resolution thereunder. Any PMG review mechanism for services-related issues shall be subject to the approval of and shall be consistent with the relevant provisions of the Certificate(s) and the established grievance procedure.

15.04 In the event any complaint or grievance of a Member cannot be settled through the grievance mechanism referenced in Section 15.01, 15.02 or 15.03, such matter shall be submitted to binding arbitration in accordance with the terms of the Member's Certificate. In that event, the parties hereto agree to cooperate and, at the request of a party, participate in any arbitration proceedings arising therefrom and, subject to either party's right to seek judicial review thereof in accordance with the terms of the Certificate, to abide by all provisions of any final award rendered as a result of such proceedings.

ARTICLE XVI

RELATIONSHIP-OF-PARTIES

16.01 None of the provisions of this Agreement are intended, nor shall they be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement; neither is this Agreement intended, except as may otherwise be specifically set forth herein, to create a relationship of agency, representation, joint venture, or employment between the parties. Unless mutually agreed, nothing contained herein shall prevent PMG from independently participating as a provider of services in any other Health Maintenance Organization or system of prepaid health care delivery so long as is notified one hundred eighty (180) days in advance of any arrangements to do so. In such event, PMG shall provide written assurance to that any contract providing commitments to any other prepaid program will not prevent PMG from fulfilling its obligations to Members under the Agreement, including the timely provision of services required hereunder.

16.02 Nothing contained in this Article shall limit the right of to perform monitoring functions as required by applicable state and federal law, as amended.

ARTICLE XVII

INDEMNIFICATION

17.01 PMG and Member Physicians furnishing care or other benefits to [illegible] Members do so as independent contractors (or subcontractors) with [illegible] and [illegible] shall not be liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries suffered by the Member while receiving care from, or authorized by, PMG or a Member Physician.

ARTICLE XVIII

MISCELLANEOUS

18.01 Assignment. [illegible] or PMG, pursuant to mutual written agreement, may assign rights and duties established under this Agreement, provided that no such assignment shall adversely affect the rights or duties of [illegible] Members or be in conflict with the requirements of the state or federal laws under which [illegible] is licensed or qualified.

18.02 Amendment. [illegible] and PMG may amend this Agreement by written mutual consent.

18.03 Severability. If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

18.04 Notices. Any notice required or permitted to be given pursuant to this Agreement shall be in writing and shall either be personally delivered or sent by registered or certified mail in the United States Postal Services, return receipt requested, postage prepaid, addressed to each party at its respective last known address.

18.05 Entire Agreement. This Agreement, together with Exhibits, contains the entire agreement between [illegible] and PMG relating to the rights granted and the obligations assumed by this Agreement. Any prior Agreement, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

18.06 Headings. The headings of articles and paragraphs contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

18.07 Governing Law. The validity, construction, interpretation and enforcement of this Agreement shall be governed by the laws of the State of California.

18.08 Conflict of Interest. PMG shall not, during the term of this Agreement, hold, acquire, or make any commitment to acquire a proprietary interest in any organization which is licensed or qualified as a health care service plan or Health Maintenance Organization or which has submitted an application for such licensure or qualification. "Proprietary Interest", as used herein, shall not be deemed to include: (a) participation as a provider of services for any other Health Maintenance Organization or system of prepaid health care delivery; or (b) ownership of less than five percent (5%) of the outstanding stock of a corporation whose shares are

regularly traded in a public market. PMG shall not, either during or after the term of this Agreement, solicit any patient seen as a [redacted] Member on behalf of any other Health Maintenance Organization or prepaid health care service plan. "Solicit", as used herein, shall not be deemed to include merely accepting a former [redacted] Member as a patient under another prepaid health plan in the absence of any endorsement, recommendation or promotion of such other plan by PMG.

18.09 Proprietary Information. PMG acknowledges that the names, addresses and other identifying information concerning Members and employers and other groups contracting with [redacted] constitute confidential information which derives independent economic value from not being generally known or readily accessible to others who can obtain economic value from its disclosure or use. PMG shall use such information only as necessary and appropriate for the performance of its obligations under this Agreement and shall make reasonable efforts to protect such information from unauthorized use or disclosure.

1991 AMENDMENT TO THE 1990 PROVIDER SERVICES AGREEMENT

The 1990 Provider Services Agreement between [redacted] and [redacted] (hereinafter "the Agreement") is hereby amended effective January 1, 1991 as follows:

1. Section 1.01 of the Agreement is amended by deleting the words "prepaid hospital service plan" and submitting in their place the words "health care service plan licensed pursuant to the Knox-Keene Act".

2. Section 2.05 of the Agreement is deleted in its entirety and replaced with the following:

   "Coverage Certificate" or "Certificate" is the Evidence of Coverage and any amendments thereto, issued in connection with the Hospital and Professional Service Agreement between [redacted] and an enrolled group or the Plan Agreement issued to an individual. The Agreements establish the services to which Members are entitled. A summary of the benefits of each plan type is set forth in the [redacted] Participating Medical Group Operations Manual (hereinafter "the Operations Manual").

3. Section 2.08 of the Agreement is deleted in its entirety and replaced with the following:

   "Enrollment Area" is that portion of [redacted] service area established by [redacted] or the Participating Medical Group or Independent Practice Association selected by the Subscriber to assure reasonable access to care.

4. Sections 2.17 through 2.20 of the Agreement are renumbered 2.18 through 2.21. A new section 2.17 is added as follows:

   "Service Area", for the purpose of determining in-area versus out-of-area services, is the geographic area in the Continental United States within a 30-mile radius of the Participating Medical Group or the designated central location for the Independent Practice Association.

6. Section 5.02 of the Agreement is amended by deleting the words "Enrollment Area" from the first sentence and adding the words "Service Area" in their place.

7. Section 5.31 of the Agreement is amended by deleting the words "abide by", and replacing them with "apply, as determined medically appropnate by PMG".

5. The first sentence of Section 5.03 of the Agreement, is amended to read as follows:

"To provide medical social services, (hospital discharge planning, social services counseling, and referrals for services not covered under this Agreement), patient education, home health care and mental health care or arrange with community agencies to provide such services".

6. Section 5.28 of the Agreement, is amended by adding a new sentence, #6, to read as follows:

6. Notification of Medical Management department prior to any admission of a Member for an elective procedure (inpatient or outpatient) to a Hospital, Skilled Nursing Facility, Free Standing Surgery Center, or Outpatient Hospital Based Surgery Center. For emergency services and out-of-area admissions, notification within forty-eight (48) hours is required.

7. The last paragraph of Section 5.28 is hereby stricken and deleted and replaced with the following:

"PMG agrees that a member of Utilization Review and Quality Assurance Medical Staff may, where Case Management deems necessary, participate in PMG's Quality Assurance and Utilization meetings relating to Members. In addition, PMG shall provide with copies of the minutes of such meetings relating to lembers within ten (10) business days of receipt of a written request for same from

8. Section 5.29 of the Agreement, is hereby stricken and deleted and replaced with the following:

That Medical Director or designated representative will be involved in the management of catastrophic cases including organ transplantation, the care of patients with Acquired Immune Deficiency Syndrome (AIDS), cases that arise outside of a PMG's Service Area, and other cases where Case Management is deemed necessary and appropriate by Medical Director or designated representative and where the Member's attending physician at the PMG does not conclude that such involvement is medically inappropriate.

9. Section 5.30 of the Agreement, is hereby stricken and deleted and replaced with the following:

PMG agrees to actively participate with Medical Director or designated representative to facilitate the management of such catastrophic cases identified in Section 5.29, unless such participating by is reasonably deemed by PMG to be medically inappropriate. Such participation includes notification of of all known or suspected catastrophic cases, receiving prior confirmation of coverage under the Member's plan for organ transplantation evaluations and organ transplantations, providing information that may be required in the transfer of a Member to a facility within the PMG's Service Area, and utilizing regional centers designated by for the purpose of delivering specialized care. Detailed procedures for case management shall be set forth in the Operations Manual, unless PMG reasonably concludes that use of such regional center is medically inappropriate.

10. Article IX, Section 9.01 of the Agreement, is amended by adding the following sentence to the end of the section:

"Capitation for Members shall be paid according to the methodology set forth in Exhibit E".

11. Article IX, Section 9.03 of the Agreement, is hereby amended by adding the following sentence to the end of the section.

"Wellness Capitation for [redacted] POS Members shall be paid according to the methodology set forth in Exhibit E".

12. Article X, Sections 10.01 and 10.02 of the Agreement, are amended to add the following sentence to the end of each section:

"For [redacted] POS Plan membership, refer to Exhibit E".

13. Article XI, Section 11.01 of the Agreement, is amended to add the following sentence to the end of the paragraph:

"For [redacted] POS Plan membership, refer to Exhibit E".

14. The 1991 Amendment, Section 11.05 is hereby amended changing the Enrollment Protection reimbursement from ninety percent (90%) to seventy-five percent (75%).

15. Article XII, Sections 12.02, 12.03, 12.04, 12.05, and 12.07, are amended to add the following to the end of each section:

"For [redacted] POS Plan membership, refer to Exhibit E".

16. Exhibits B, C and D shall be deleted in their entirety and replaced with Exhibits B, C, and D attached and incorporated herein.

Exhibit C – 1992
Contract Based Professional Capitation

[redacted] AMENDMENT

1992 Reassigned Total Professional Capitation Without MHCD

Single	Two Party	Family	1 Adult+Deps
47.21	94.42	136.91	89.70
47.73	95.46	138.42	90.69
44.05	88.10	127.75	83.70
44.05	88.10	127.75	83.70
39.41	78.82	114.29	74.88
39.41	78.82	114.29	74.88
47.21	94.42	136.91	89.70
47.21	94.42	136.91	89.70
47.21	94.42	136.91	89.70
44.05	88.10	127.75	83.70
48.96	97.92	141.98	93.02
47.21	94.42	136.91	89.70
44.87	89.74	130.12	85.25
41.71	83.42	120.96	79.25
44.05	88.10	127.75	83.70
41.45	82.90	120.21	78.76
44.05	88.10	127.75	83.70
44.58	89.16	129.28	84.70
26.02	52.04	75.46	49.44
47.21	94.42	136.91	89.70
49.48	98.96	143.49	94.01
44.05	88.10	127.75	83.70
44.31	88.62	128.50	84.19
44.31	88.62	128.50	84.19
44.05	88.10	127.75	83.70
44.05	88.10	127.75	83.70
44.05	88.10	127.75	83.70
44.58	89.16	129.28	84.70
44.58	89.16	129.28	84.70
44.12	88.24	127.96	83.83
44.31	88.62	128.50	84.19
41.45	82.90	120.21	78.76
41.97	83.94	121.71	79.74
41.97	83.94	121.71	79.74
41.45	82.90	120.21	78.76
44.58	89.16	129.28	84.70
41.45	82.90	120.21	78.76

1992 Reassigned Total Professional Capitation Total (With MHCD)

Single	Two Party	Family	1 Adult+Deps
48.29	96.58	140.04	91.75
48.82	97.64	141.58	92.76
45.14	90.28	130.91	85.77
45.14	90.28	130.91	85.77
40.50	81.00	117.45	76.95
40.50	81.00	117.45	76.95
48.74	97.48	141.35	92.61
48.42	96.84	140.42	92.00
49.25	98.50	142.83	93.58
45.27	90.54	131.28	86.01
50.17	100.34	145.49	95.32
48.42	96.84	140.42	92.00
46.40	92.80	134.56	88.16
43.25	86.50	125.43	82.18
45.14	90.28	130.91	85.77
42.53	85.06	123.34	80.81
45.14	90.28	130.91	85.77
45.66	91.32	132.41	86.75
26.02	52.04	75.46	49.44
48.74	97.48	141.35	92.61
52.54	105.08	152.37	99.83
45.27	90.54	131.28	86.01
45.94	91.88	133.23	87.29
45.52	91.04	132.01	86.49
45.69	91.38	132.50	86.81
45.27	90.54	131.28	86.01
45.27	90.54	131.28	86.01
45.79	91.58	132.79	87.00
45.79	91.58	132.79	87.00
46.57	93.14	135.05	88.48
45.52	91.04	132.01	86.49
42.66	85.32	123.71	81.05
43.18	86.36	125.22	82.04
43.18	86.36	125.22	82.04
43.08	86.16	124.93	81.85
45.79	91.58	132.79	87.00
42.66	85.32	123.71	81.05

43.62	87.24	126.50	82.88	46.67	93.34	135.34	88.67
44.04	88.08	127.72	83.68	45.25	90.50	131.23	85.98
49.48	98.96	143.49	94.01	52.54	105.08	152.37	99.83
47.73	95.46	138.42	90.69	49.26	98.52	142.85	93.59
39.53	79.06	114.64	75.11	40.62	81.24	117.80	77.18
42.14	84.28	122.21	80.07	43.22	86.44	125.34	82.12
47.21	94.42	136.91	89.70	48.42	96.84	140.42	92.00
47.46	94.92	137.63	90.17	48.68	97.36	141.17	92.49
47.73	95.46	138.42	90.69	48.95	97.90	141.95	93.01
44.97	89.94	130.41	85.44	46.61	93.22	135.17	88.56
47.90	95.80	138.91	91.01	49.12	98.24	142.45	93.33
45.88	91.76	133.05	87.17	47.37	94.74	137.37	90.00
41.45	82.90	120.21	78.76	42.53	85.06	123.34	80.81
41.60	83.20	120.64	79.04	42.68	85.36	123.77	81.09
41.97	83.94	121.71	79.74	43.06	86.12	124.87	81.81
39.22	78.44	113.74	74.52	40.31	80.62	116.90	76.59
39.22	78.44	113.74	74.52	40.44	80.88	117.28	76.84
39.22	78.44	113.74	74.52	40.31	80.62	116.90	76.59
44.05	88.10	127.75	83.70	45.14	90.28	130.91	85.77
39.41	78.82	114.29	74.88	40.50	81.00	117.45	76.95
24.22	48.44	70.24	46.02	24.22	48.44	70.24	46.02
13.94	27.88	40.43	26.49	13.94	27.88	40.43	26.49

EXHIBIT D

CONTRACT VARIABLES

SATELLITES/BRANCH OFFICES

All the PMG's branch offices or satellites which are also included within the scope and terms of this Agreement are listed below:

PMG #	Satellite/Other Location Name and Address	Capacity
[redacted]	[redacted]	3,000
_____	_____	_____
_____	_____	_____
_____	_____	_____

MAXIMUM CAPACITY

PMG's maximum capacity at the main location shall be 8,000 [redacted] Members.

ADDITIONAL INSURED SERVICES

Additional services for this contract year include:

A. Short-term neuromuscular rehabilitative services: Professional services for neuromuscular rehabilitative services beyond 60 consecutive days will be covered if the Member's Primary Care Physician (PCP), PMG, and [redacted] Case Management determine that additional therapy will likely result in a significant improvement in the Member's condition.

B. Long-term neuromuscular rehabilitative services: For benefit plans which include the long-term neuromuscular rehabilitative benefit, professional care and hospital care rendered beyond one year of care will be covered if the Primary Care Physician (PCP), PMG, and [redacted] Case Management agree that additional therapy will likely result in a significant improvement in the Member's condition.

C. Immunization for travel: Average wholesale price of the immunization, less the 20% Member copayment.

D. 30-day coverage for adopted children: Professional services for the adopted child during the first 30 days after the date the member acquires physical custody.

E. Haemophilus B (HIB) vaccine: 50% of the average wholesale price (AWP) of Haemophilus B (HIB) vaccine or 50% of PMG's actual cost of HIB vaccine, whichever is less.

ENROLLMENT PROTECTION PROGRAM

4/20/93

PMG hereby: (elects to) _____, (elects not to) _____ participate in the Enrollment Protection Program. PMG's Enrollment Protection level shall be $ ~~18,000~~ 15000 per [redacted] Member during this calendar year for all locations. The cost to the PMG for the Enrollment Protection level shall be $ ~~1.38~~ .66 per enrolled Member per month.

The cost to the PMG for the 1993 Enrollment Protection will be adjusted to reflect [redacted] overall experience.

AIDS AND TRANSPLANT POOLS

A Special pool shall be created to cover the costs of care rendered to Members with Acquired Immune Deficiency Syndrome (AIDS), with the contribution of sixty-five cents ($0.65) per Member per month (pmpm) from the PMG's capitation payments and sixty-five cents ($0.65) per Member per month (pmpm) from [redacted]

A Transplant pool shall be created to cover one hundred percent (100%) of Institutional costs approved and directly related to the transplant, as well as ninety percent (90%) of the Professional costs as outlined in the conversion factors found in Exhibit B approved and directly related to the transplant, including approved transplant evaluations, with the contribution of sixty-three cents ($0.63) per Member per month (pmpm) from the PMG's capitation payments and seventy cents ($0.70) per Member per month (pmpm) from

The money in the two pools will be combined for the purpose of the annual settlement. In the event that the pools are exhausted prior to the end of the calendar year, costs will be the responsibility of [redacted] Any surplus funds will be carried forward to the following year.

Contributions to the AIDS and Transplant Pools in 1993 will be based on the trend of costs in the prior two years and anticipated changes in treatment modalities.

SHARED RISK

For Shared Risk purposes, each numbered site will be treated as a separate entity. Final settlement is calculated by site. Final payment to PMG with multiple sites will be net the amount due/owed from all sites.

1. Gross Shared Risk Revenue shall be $ 37.60 per Member per month.[1]

---

1. [redacted] *Members who have Medicare as their primary payor are not included in the Shared Risk program; therefore, such Members are not included in the calculation of Gross Shared Risk Revenue.*

2. The annual cost of [redacted] Reinsurance for PMG during this calendar year shall be a total of 11.35 percent of Gross Shared Risk Revenue.

   Out-of-Area Reinsurance: 3.75 percent

   In-Area Reinsurance: 7.60 percent

3. Shared Risk claims credited for any one [redacted] Member per calendar year shall not exceed $ 75,000 plus twenty percent (20%) of any amount over $ 75,000 up to $ 150,000 and ten percent (10%) of any amount over $ 150,000 .

   Twenty percent (20%) of the cost of out-of-area services shall be credited against the Shared Risk Revenue.

4. PMG shall participate in the final Shared Risk settlement as follows:

   - 50% of the Shared Risk gain.

3. PMG prescription cost per Member per month (pmpm) must be $8.00 or less.

PMG Participation Level:

1. If PMG meets the Criteria for Participation, then twenty-five percent (25%) of the reduction in total network prescription expenses per Member per month (pmpm) between year-end 1991 and year-end 1992 will be distributed to the PMG based on the PMG's 1992 Member months.

Additional Considerations:

1. If the 1992 PMG pmpm goal is achieved without reacning formulary or generic goals, the PMG will receive a ten percent (10%) incentive. If the PMG pmpm for 1992 is less than its 1991 pmpm, it will be eligible for a ten percent (10%) bonus (if it qualified for the 1991 incentive).

ENCOUNTER PROGRAM

[redacted] shall pay PMG one percent (1%) of capitation per Member per month (pmpm) in consideration of PMG participating in [redacted]'s encounter program and if reporting criteria are satisfied as set forth in the PMG Operations Manual. The data must have an error factor of less than ten percent (10%), be complete, comprehensive, and inclusive of all outside referrals, and be submitted through electronic media. The Encounter bonus will be paid on a quarterly basis.

[redacted] CAPITATION

shall pay PMG one percent (1%) of capitation per month for the initial twelve months (12) of participation in the " " program, and one-half percent (.5%) of capitation per month thereafter in consideration of PMG offering a [redacted] approved [redacted] " program to [redacted] Members, but only so long as PMG continues to meet [redacted] nteria as set forth in the PMG Operations Manual.

In 1992 [redacted] hall award special bonuses annually after the annual site evaluation for exemplary PMG efforts which exceed the program criteria. These awards will equal the [redacted] capitation paid to the PMG in the preceding six months (6).

SHARED RISK EXAMPLE

30,000 Members at 12/31/89
354,200 Member months for the entire year*
Gross Shared Risk PMPM** is 32.42 PMPM**
Hospital Reinsurance $80,000 attachment points at 4.9%
Out of Area (OOA) Reinsurance is 3.5%
Shared Risk Claim expense after reinsurance is $7,778,232.00

Gross Shared Risk = 354,200 x 32.42 =	$11,483,164.00
Less Hospital Reinsurance 4.9%	< 562,675.04>
Less OOA Reinsurance 3.5%	< 401,910.74>
Shared Risk	10,518,578.22
Less Shared Risk Claim	<7,778,232.00>
	2,740,346.22
Payment to PMG (50%)	x .5
Shared Risk Settlement	1,370,173.11
	or
	= $3.87 PMPM**

* Members with Medicare Parts A & B on a discounted premium are not included in this calculation.
** PMPM = Per Member per Month
***Assumption: Claims paid by Medicare or by either the AIDS or Transplant Pool are excluded.

DISTRIBUTION OF HMO MONTHLY PREMIUMS

Average HMO monthly premium per member	$130.00	
Shared Risk Revenue		$37.60
Reinsurance Costs	$14.76	

HMO then pays Medical Group or Independent Practice Association:

Monthly Capitation Amount	$40.00

Independent Practice Association then pays:

Monthly Physician Capitation	$10.00

WILL QUALITY SURVIVE IN AMERICAN HEALTH CARE?
A PHYSICIAN'S PERSPECTIVE

So, what's wrong with President Clinton's proposed Health Security Act? After all, it guarantees universal coverage, which is portable and non cancelable. It denies exclusion for preexisting illnesses. Insurance premiums would be uniform for all patients in a community and would not be related to their past medical histories. These provisions are essential and should be non-negotiable. In addition, we believe it is essential that medical savings accounts should be included in any future health care system, in order to preserve our patients' right to high quality health care.

The problem with the President's plan is that it sets up a giant bureaucracy which stands between the doctor and the patient, with rules of treatment dictated by the Government and the large corporations who will dominate the Health Alliances. And even if the plan is modified, most of the competing proposals before Congress stress managed care, an unproven commodity, which we believe will be seriously detrimental to the health of our patients.

So what would we practicing physicians support in any future health care system? After all, we treat the patients and best understand their needs. Our requirements are simple. We must be allowed to continue to provide high quality care, and our patients should have the right to choose all of their physicians. We also request, as a consumer right, that Health Maintenance Organizations reveal to the public, in advance, how their physicians are paid. When H. M. O. physicians are rewarded for not referring to specialists or for not ordering expensive procedures, our patients have a right to know.

Patients should also be informed about the capitation mechanism of compensation for H. M. O. physicians. As an example, under the President's scenario, dermatologists in Los Angeles will be paid at a rate of twenty five cents per month, for each patient , effectively eliminating all surgery, other than for skin cancer. This form of per capita or capitation payment to physicians, central to the President's package, punishes us physicians for quality and rewards us for providing sub-standard care. Why not have negotiated fee schedules for physicians, rewarding quality rather than volume?

In a recent eighty eight million dollar judgment against Health Net, financial incentives for physicians and executives were exposed in a court of law. This is the first such case to be tried in the United States. Similar cases against H. M. O.s have previously been settled out of court. As part of earlier settlements, plaintiffs have agreed to gag rules, preventing them from discussing their cases in public.

So what has created the health care financing crisis, which has led to the proliferation of Health Maintenance Organizations? The answer is that the combination of an aging society and advancing technology is literally breaking the bank. We have a health care system which is literally being overwhelmed by its own medical advances. The number of coronary bypass operations rose from 14,000 in 1970 to 165,000 in 1991. Each new breakthrough in biotechnology adds fuel to the fire, thereby increasing the costs of medical care.

Today, research is commonly financed and promoted for the benefits of hospitals and teaching centers. It is not unusual to find research teams headed by hospital employees who are, at the same time, part owners of the company funding the research. What's the answer, then? Technology should be evaluated on the basis of need and value to society. Hospitals and other institutions should share resources, rather than buying unnecessary sophisticated equipment in order to compete with their neighbors, thereby increasing medical costs.

Why is this important? If technology is not to be evaluated by need and by value, then the only other option is rationing of resources. When Dr. William Schwartz of Tufts University studied managed care between 1980 and 1990, he concluded that, "Given the rapid advances in medical technology, the only way in which managed care can slow long-term rising costs will be to limit the availability of beneficial services." He pointed out that managed care companies could contain costs by "silent rationing", or the decision to use less costly but less effective intervention without the knowledge of the patient. Unfortunately, this technique is standard practice with many H. M. O.s today.

In addition, physicians are in fear of being terminated by H. M. O. plans if they publicly share their private concerns about the quality of care in the plans with whom they participate. In other words, the doctor is prevented from telling the patient that the best physician or best source of treatment is not an option in the patient's plan.

Since it is almost certain that H. M. O.s will dominate under the President's plan, what's the alternative? To answer this question,. let's look at how our health care dollars are actually spent. Only 10% of the American public is responsible for over 70% of annual health care costs. 5% of the public accounts for over 50% of the total. Our health care dollars, then, are spent primarily on advanced technology used on those patients with serious or catastrophic illnesses. We believe that this is appropriate utilization of medical resources.

Everyone wants the best that American medicine has to offer, but how are we going to pay for it? The major stumbling block is that we, as a nation, are over-insured for minor illnesses. This situation will be magnified by the President's proposal, which sets insurance deductible payments at $100 or $250 for all. This type of insurance coverage is both wasteful and counter-productive. 90 % of insurance claims are for amounts under $1500. This is the ultimate in administrative waste. With 200 new bureaucrats in each new "Alliance", we'll have a whole new definition of waste. Patients should be allowed to choose high deductible health insurance policies, with direct access to any physicians of their choice. These policies should be combined with medical savings accounts, funded by the savings from reduced insurance premiums. These Medi-Save accounts could be used to pay minor medical bills not covered by the insurance plan or to purchase long-term care insurance. Moneys remaining would accumulate tax-free, but could be used at any time to fund any medical need. The end result would be that patients and their physicians would make decisions on minor medical problems, since it would no longer be the insurance companies' money.

The President has long maintained that the cause of medical inflation is massive waste in the system. Current research has shown that elimination of waste will only decrease medical costs by one and one half percent a year. Medical savings accounts, on the other hand, would be a valuable tool in insuring proper utilization of medical resources. We believe that Medi-Save accounts must be included in any health care financing proposal. One size doesn't necessarily fit all. If our patients want to choose high quality health care, why shouldn't they have that right?

HMO Physicians' Shared Risk Pools Are Dangerous To Patients' Health

By Ronald Bronow

On November 5, 1992, the CBS-TV program *Street Stories* accurately portrayed two horror stories created by a physician payment system used in most for-profit health maintenance organizations (HMOs), the so-called shared risk pools. In the most shocking story, a woman, through self-examination, found a lump in her breast. She went to her HMO physician and was told "it was only a cyst." When the patient requested a mammogram, she was told that it was not necessary. In spite of objections by the patient and her husband, the doctor remained firm in his refusal to order the test. Five months elapsed, during which time the patient noticed another lump. At this point, the doctor finally relented, and a mammogram was ordered.

As the mammogram was highly suspicious, a biopsy was done. Unfortunately, the clinical diagnosis of breast cancer was confirmed. On subsequent surgery the patient was noted to have regional metastasis to five auxiliary lymph nodes. Subsequently, the cancer metastasized to the liver and to the bones.

Unhappy with the therapeutic options offered by her HMO, the patient went to a large medical center, specializing in cancer therapy. She was advised to have an immediate bone marrow transplantation; this being the only hope to save her life. Her HMO refused to authorize the procedure. Her family then proceeded to institute a lawsuit against the HMO. At this point, the HMO relented and authorized the procedure, twenty-four hours before the scheduled operation. The patient did well after the procedure, and so far there has been no evidence of recurrence of the cancer.

Risk Pool Mechanism

Why did this happen? The HMO spin doctors will tell you that this story is anecdotal, only an aberration. However, the truth is that this is not all that uncommon. Such horror stories are a direct result of the HMO shared risk pool, a physician payment mechanism that strikes at the quality core of American medical care. So how does this system work?

When a patient decides to join an HMO he or she is given a list of primary care doctors, known as "gatekeepers." The patients must choose their personal physician from this list only. Each of the listed physicians is then given a monthly per capita payment for each patient assigned to him or her. The physician receives this payment each month whether or not he sees the patient during that month. This system is known as capitation. The physician assumes the risk that his expenses will not be greater than the payments from the HMOs.

> A policy that makes physicians restrictive gatekeepers disrupts the trust that is so important to the doctor-patient relationship.

For example, let's assume that the doctor gets $10 a month per patient. If he sees the patient 10 times, it equals $1 per visit. If he doesn't see the patient at all, he still gets $10 for the month. But the story doesn't end there. The physician may receive only $7 or $8 of the entire $10 capitation payment with the remainder put into a shared risk pool. What's left in this pool at the end of the year is divided between all the participating primary care doctors. The catch is that the physicians are notified that this pool will decrease if doctors order laboratory tests, x-rays or additional consultations. The physician, therefore, is given financial incentives not to do his or her best and is no longer the advocate of the patient, but may become the patient's adversary.

Risk Pools Lead to Malpractice, Fraud

A policy that makes physicians restrictive gatekeepers disrupts the trust that is so important to the doctor-patient relationship. The patient is already made vulnerable by disease and his own lack of medical expertise, so he is at increased risk for exploitation in a system of shared risk pools. The patient, assuming that he knows about the

Dr. Ronald Bronow, M.D., president of Physicians Who Care, is a dermatologist in private practice in Los Angeles. Physicians Who Care is a national organization of private practice physicians based in San Antonio, Texas. Dr. Bronow is the senior author of "The Physicians Who Care Plan—Preserving Quality and Equitability in American Medicine," printed in a special issue of the May 15, 1991 *Journal of the American Medical Association*. Physicians Who Care may be contacted by calling (1) (800) 545-9305.

doctor's financial incentives, must always be wary that the physician might be avoiding a costly referral or expensive treatment because of personal financial considerations. This disruption of trust between doctor and patient, to me, is too high a price to pay for cost savings. The saddest part is that the patient, trusting his physician, may not be aware that he might need further testing and consultations.

When financial incentives are provided to physicians to limit costs, the interests of patients and physicians become diametrically opposed.

So how many patients actually know about physician financial incentives in for-profit HMOs? Unfortunately, very few. Why aren't the patients told in advance? The answer is simple. Wouldn't you think twice about joining a plan if you were told that your physician would be paid more for not referring you to a specialist or for not ordering laboratory tests? Of course you would. But the HMOs don't want you to have this information (or conveniently put it in small print) because you might decide not to join the plan.

Physicians Who Care will not compromise with a system that withholds such vital information from our patients. Patients have a right to know, before they join, about physician financial incentives from an HMO. Anything less than full and complete disclosure is nothing less than consumer fraud.

So why is this happening? The answer is simple—corporate profit. Large corporations have convinced our government that they can get a handle on medical costs by doing away with "unnecessary medical care." The corporations that own large, for-profit HMOs are, after all, businesses. In this sense, however, the product of the business is the patient, who has become a commodity. Medical care is rationed so that the corporation may show a profit.

I remember attending hospital staff meetings in Los Angeles in the mid-1980s, hearing corporate representatives pressure physicians into joining HMOs. They openly threatened that doctors would lose their practices unless they joined. We were advised that we could not compete with massive HMO advertising campaigns and our patients would leave us. We were informed that managed care was the future of American medicine. We physicians would be powerless to change it, and we and our patients had better get used to the fact that physicians were no longer in control of the American health care system.

Who Profits from Health Care Decisions?

Now that's the real issue. Large corporations, in the name of cost containment, are attempting to wrest control of the American health care system from physicians and their patients. Their battle cry is "Physician greed is the root cause of the American health care crisis." They argue that the rising costs of health care will be best controlled by plans that assign a restrictive gatekeeping role to the physician. They further maintain that in the fee-for-service system the physician has a financial incentive to order unnecessary tests and treatments in order to generate profit. Their conclusion is that financial incentives for limiting service are necessary for cost control and that fee-for-service encourages cost escalation.

However, this explanation is too simplistic. First, in fee-for-service, the interests of the patients are generally the same as those of the physicians. Both parties want the patient to get better as quickly as possible. Physicians who abuse the privilege of patient trust, by ordering

TIME-SAVING NEW DEVELOPMENT

HealthSpan now available on WESTLAW®!

- Save time using WESTLAW computer-assisted legal research service
- Retrieve legal and other secondary information easily on WESTLAW
- To access *HealthSpan* online, simply type PH-HTHSP after accessing WESTLAW.

For more information, call 1-800-328-9352

More ways to win

unnecessary tests or procedures should be condemned. Physicians must insist on the establishment of scientific guidelines for medical care. Physicians who stray from these guidelines for personal profit simply should not be compensated. Physicians should be compensated for appropriate medical care.

But is physician greed really the issue? Physicians Who Care has consistently opposed physicians over charging for services, as all physicians are blamed for the acts of this small minority. Yet, overall, physician earnings comprise 9 percent of total U.S. health care costs. If you cut all physicians' earnings down by one-third, the total share becomes 6 percent of health care expenditures. That's hardly enough to keep up with medical inflation or pay for 37 million people without health insurance.

On the other hand, when financial incentives are provided to physicians to limit costs, the interests of patients and physicians become diametrically opposed. The more the physician attempts to help the patient, the less the physician is compensated. That is an unfair burden for any physician to carry. Would you rather have one extra test to confirm the cause of your chest pain or one less test so the corporation may show a higher profit? The bottom line is that HMOs should provide full disclosure to prospective patients on how their plans work.

Does Gatekeeper System Work?

I have discussed how any services that a patient receives under an HMO program have to be authorized by the primary care doctor, the "gatekeeper." Why should the patient have to ask for permission for anything regarding his or her health care? Not only should patients have access to all necessary laboratory tests, they must have direct access to care, whether by generalists or specialists.

The HMOs argue that specialists are too expensive and order unnecessary tests. An interesting study was done in my field, dermatology. This study evaluated the ability of primary care physicians to recognize the 20 most frequently encountered skin conditions seen by dermatologists. The overall performance of all 285 primary care physicians showed an accuracy score of 54 percent. Dermatology residents and practitioners consistently scored over 90 percent.

This study's results mean that an HMO gatekeeper system may actually increase medical costs because of: (1) additional visits to the same physician because of failed therapy caused by misdiagnosis means added cost; (2) subsequent referral to a dermatologist to establish a correct diagnosis or resolve a poor outcome resulting from the initial misdiagnosis means even more cost; (3) additional diagnostic or laboratory procedures necessitated by lack of diagnostic expertise by the primary care physician means even more expense; (4) ineffective medications that were prescribed because of misdiagnosis, including unnecessary surgery or biopsies, adds even more cost; and (5) the monetary value of lost time because of additional trips to the physician, the actual cost of travel, and the cost of time lost from work because of disability from inadequately treated diseases adds even more. This study poses a real question as to the value of HMO restrictions to access for specialty care.

Another example of a fundamental change in the doctor/patient relationship in a gatekeeper system is in the way physicians must refer patients for other consultations, second opinions or surgery. The physician is required to agree to send the patient to a consultant or surgeon on the HMO's "approved list." While in medical school, I made a commitment of personal ethics to my patients: to refer them to another physician or service only if I would have that physician treating me or a member of my family. But when I look over the list of participating doctors in many HMOs, I find that, in some areas, physicians to whom I would be required to refer a patient do not meet my personal ethical and professional standards. Furthermore, although the physicians on the lists are changing constantly, I would not be allowed to refer a patient to a physician who no longer participates.

HMO Contracts with Physicians

The part of an HMO program that a patient will never see is the contract that the physician participating in that program is required to sign. That is because HMOs do not want their patients to know what types of limits and financial incentives are being given to their primary care physician and to others on the HMO's approved list.

In many HMO contracts that physicians must sign is a section which forbids "the participating physician" from criticizing the HMO, its method of payments and disputes with the company over incorrect, slow or inadequate payments. Furthermore, the physician may not criticize the plan with regard to any of the other participating physicians nor comment on the physicians or hospitals who are not participating in the plan.

In other words, the doctor is prevented from telling his patient that the best physician or the best source for treatment is not a participant in the patient's plan and is therefore not an option for that patient. If the doctor is not allowed to tell the patient this, how is the patient supposed to know? After all, the patient trusts the doctor to do his best. Is this the future of American medicine? I, as one physician, will never sign a contract that requires me to deceive my patients.

Managed Competition: Myth and Reality

The new buzz words in health care are "managed competition." Part of the theory of managed competition is that buying agents would bargain between competing HMOs on behalf of groups seeking coverage. The theoretical result would be contracts that drive overall costs down. In this system, the insurance industry, with their HMOs, would gain absolute power in operating the American health care system. The result would be to remove all choice and independence from the majority of health care seekers and health care providers.

In order to make managed competition work, employees would be coerced into cut-rate health maintenance organizations. Here, hospitals, doctors and other health care workers would also be under the direct control of the insurance companies. Tax penalties would inhibit those seeking care outside the HMO environment.

The reality would be a class-based system, with poor people in cut-rate HMOs at the bottom, and the rich opting out for top-class health care. The HMOs would then have every incentive to reduce their costs by restricting services to the truly sick.

After all of this, you would assume that HMOs have dramatically reduced health care costs. Otherwise, why would physicians be forced to drastically ration their patients' care? Actually, the Congressional Budget Office reports that HMOs have had no significant effect on American health care costs during the 1980's and will have even less effect during this decade. Further, another study has shown that 30 percent of Medicare patients disenroll from HMOs within two years of joining. After all, they are the ones who really test the system. They need the care.

Physicians and Patients Must Fight Back

In the rush towards increasing the use of managed care to tackle America's health care crisis, patients need to be aware of how an HMO works before joining. Patients have the right to know the full extent of the financial incentives that may be in existence for doctors to limit care. Physicians Who Care has prepared an extensive HMO checklist of questions that consumers can use to evaluate HMOs before they join. Physicians in private practice cannot allow patients to receive inferior care in order to promote corporate profits. Only by educating patients can we counter the attempted corporate takeover of American medicine.

We physicians took a Hippocratic Oath to do our best for our patients. But the HMO creates a basic conflict of interest for the physician. The physician is rewarded for deliberately limiting care, not for the good of the patient, but for generation of profit for the corporation. An HMO that puts its physicians in a gatekeeper role by offering financial rewards or penalties for tests or referral, places physicians in an ethically and professionally untenable position. Physicians must feel free to make medical decisions based on the needs of the individual patient without fear of economic sanctions or reprisals.

Reprinted from HealthSpan with permission.

Coalition For Consumer Protection And Quality
In Health Care Reform

White Paper On
Consumer Due Process Protections

November 30, 1993

Executive Summary

This white paper identifies and examines key consumer notice, appeal, and grievance rights -- collectively referred to as consumer "due process" rights -- essential in any national health care legislation and consistent with the Clinton Health Bill. Section I, the Executive Summary, provides an outline of these rights. Section II is an analysis of the key principles arising under federal statute, case law, and constitutional law that a impact on the nature and scope of due process in the delivery of health care services.

I. **EXECUTIVE SUMMARY: Outline of Necessary Due Process and Consumer Protection Elements In National Health Care Reform**

A. **Broad Societal Interests In An Appeals Process That Is:**

- - **Fair**

- - **Accountable**

- - **Timely**

B. **Specific Due Process and Consumer Protection Elements**

1. Appeals Process. An appeals process shall be established for patients for whom health care services or payments have been denied, reduced, or terminated. The appeals process shall have the following components:

   o Written notice shall be given to the patient by the insurer or health plan for:

      a) any decision to deny or reduce requested services;

      b) all terminations of institutional care, such as hospital, nursing home, home health care;

      c) failure to provide specified services, such as rehabilitation services and home health services for the improvement/or prevention of deterioration of a patient's condition.

   [Regulations should be developed to specify the circumstances under which written notice of appeal rights is required and the relevant time periods for the receipt of notice.]

   o Posted Notice of the right to appeal denials, reductions, and terminations of coverage are to be appropriately displayed in public areas of all health plan facilities.

   o A "Plain Language" Explanation of appeal rights shall be provided to individuals upon enrollment in health plans.

- Expedited review of the correctness of the denial, reduction, or termination of urgently needed services must be available as follows --

  a) the patient attests that services are urgently needed and the failure to provide them promptly or the failure to continue them may impair or retard improvement or cause deterioration of the patient's health status.

  b) expedited review must be performed by an independent hearing officer, as defined below, who shall issue a written decision to the patient within two (2) days of the request for review.

  c) services or payment by the insurer or plan must continue until an expedited review decision has been issued.

- Review by an independent hearing officer for all other services shall be governed by the following administrative process --

  a) review of its denial, reduction, or termination decision must be provided by the insurer or health plan, which shall issue a written decision within 15 days of the request for review.

  b) hearing by an independent hearing officer must be available with 30 days of a review decision. An independent hearing officer is an individual who is not an employee or designee of the insurer or health plan;

  c) written decision setting out the hearing officer's rulings on issues of fact and law must be issued within 30 days of the hearing;

  d) beneficiary coverage of services in place before the insurer's or health plan's initial adverse decision shall continue pending a hearing decision when requested by the beneficiary, unless the continuation would be harmful to the beneficiary as documented in writing by the treating physician;

  e) beneficiaries shall have the right to present favorable evidence, including out-of-plan second opinions in cases challenging plans' service denials, the right to review and present information from their medical records, and the right to compel the attendance at hearings of decision-makers whose actions are under challenge;

  f) hearing officers shall have a duty to assist claimants in developing the factual record, including ordering out-of-plan second opinions.

- Judicial review shall be available in state or federal court in cases involving at least a specified threshold amount of charges, including the aggregation of claims to meet the threshold amount. Such threshold requirements can be waived for low-income persons at the discretion of the

courts. Relief for prevailing consumer-claimants should include reasonable costs and fees.

- A Private Right of Enforcement shall be available to plan enrollees to maintain an action for damages and for any other relief, including injunctive and declaratory relief, for acts or omissions of a Health Plan, Health Alliance, State, or Federal Government which deprive such an enrollee of any right or benefit created or established to implement the provisions of the Act.

- Penalties should be set by a national health board for plans and alliances that do not meet appeal rights standards and time-lines.

2. Grievance Process. A grievance procedure shall be established within each health plan for the resolution of complaints of individuals about problems other than denial, reduction, or termination of service or payment, including, but not limited to, delays in scheduling appointments, rude or undignified treatment at health plan facilities, the physical conditions of facilities, or enrollment and disenrollment disputes. The components of the grievance process are as follows --

- The right to complain orally or in writing to a Patient Advocate or other independent ombudsman who shall investigate the facts, seek to resolve the problem in a way suitable to the patient, and prepare a written report for the individual and for the plan within 15 days.

- The right to have the complaint referred to a Grievance Committee of the health plan that will recommend action in response to the complaint and report to the individual and to the plan within 30 days.

- The right to have still unresolved grievances reviewed by Health Alliances or other independent monitoring entities authorized to investigate and respond with a full range of sanctions including corrective action, civil monetary penalties, and termination of health plan status.

- Penalties should be set by the national health board for plans and alliances that do not meet grievance procedure standards and time-lines.

C. Health Plan Governance. Individual health plan beneficiaries shall have the right to substantial and meaningful participation as consumers of care in all levels of governance and decision-making in the operation of health plans, health alliances, and state and federal oversight organizations.

D. Protection of Existing Rights. Rights afforded under any Federal health reform plan should not invalidate or limit any other federal or state law or any law of any political subdivision of any state that provides greater protection for the rights of beneficiaries under health plans.

E. Alternative Dispute Resolution (ADR), Including Mediation. The use of ADR under appropriately defined circumstances can augment an appeals process. We stress, however, that ADR is not effective in situations where the only solution is "yes" or no," or in a determination of which side wins.[1] Disputes over whether a particular service is covered under the plan, whether a participant meets the eligibility criteria for particular services (such as long-term care or home health services) would not be appropriate for ADR.

There is also a concern about the unequal bargaining power of the parties to ADR and that ADR not become a vehicle for delay. Plans are likely to control the review forum, its location and setting, as well as medical and other information relevant to decision-making. In addition, ADR can have the harmful affect of deflecting consumer energy -- making them give up -- and in the process, consuming time and financial resources that could be used more appropriately.

ADR works where multiple outcomes are possible, where the parties want to maintain an on-going relationship, and where the parties want to help develop a settlement. Grievances concerning service, such as long waits, difficulties in getting appointments, rudeness and undignified treatment, may lend themselves to ADR.

II. STATUTORY DUE PROCESS PRINCIPLES AND PRECEDENTS

The Medicare and Medicaid programs[2] have served as the primary laboratories of experience in shaping due process rights in government sponsored health care programs. Because Medicare has followed a social insurance model, it offers a useful analog to the types of national health plans under consideration. In 1982, the Congress changed the structure of Medicare payments to allow and encourage Health Maintenance Organizations (HMOs) to enroll Medicare beneficiaries. HMOs receive a monthly capitated at-risk payment for each Medicare enrollee. By 1992, Medicare enrollment in HMOs had climbed to about 1.5 million persons, or about three (3) percent of total Medicare enrollees.[3] This growing segment of the Medicare program represents an even closer analog to the models of managed competition being considered for national health reform.

The Medicaid program likewise provides a useful analog, although in a different respect. Medicaid represents a Federal/State collaborative program with substantial state control

---

[1]. See, L. Singer, M. Lewis, A. Houseman, E. Singer, "Alternative Dispute Resolution and the Poor Part II: Dealing with Problems in Using ADR and Choosing a Process, " 26 Clearinghouse Review 288, 290 (July 1992).

[2]. 42 U.S.C. §1395 et seq. (Medicare); 42 U.S.C. 1396 et seq. (Medicaid). Medicare eligibility is not based on an applicant's financial status. See, 42 U.S.C. §1395c. Eligibility for Medicaid, however, is based on state income and resource requirements and status, i.e., disability. 42 U.S.C §1396a.

[3]. Nancy De Lew, et al., "Special Report: A Layman's Guide to the U.S. Health Care System," 14 Health Care Financing Review 151, 162 (Fall 1992).

over specifics of the program within federal standards. The principle of Federal/State collaboration and State flexibility are characteristic of national health reform proposals to date.

Finally, the Employee Retirement Income Security Act (ERISA) establishes federal statutory protections for participants in private employer-sponsored group health plans.[4] Due process rights under ERISA are not as extensive as the rights under Medicare and Medicaid. National health reform proposal based on the current model of employer-provided health insurance may, however, look to ERISA as the underpinning for its due process provisions.

A. Medicare Hearing Rights

With respect to denials, terminations, or reductions of services, due process for Medicare beneficiaries has been approached primarily from a constitutional protection model as outlined originally in the 1970 Supreme Court case, Goldberg v. Kelly.[5] In Goldberg, the opportunity to be heard is identified as the fundamental requisite of due process.[6] Due process is further defined as including the right to adequate notice;[7] to appear personally (with or without counsel) before an impartial decision maker; to present evidence; and to confront or cross-examine adverse witnesses.[8] Courts have recognized at least three public policy interests that favor due process hearings to mediate claims and disputes with respect to entitlements: "the desire for accuracy, the need for accountability, and the necessity for a decision making procedure which is perceived as "fair" by the citizens."[9]

Due process principles also underlie the concept of

---

4. The primary focus of ERISA is on pension plans. However, its disclosure and fiduciary duty rules, as well as its causes of action, are applicable to all employee benefit plans, including health plans.

5. Goldberg v. Kelly, 397 U.S. 254 (1970).

6. Id., at 267.

7. David v. Heckler, 591 F. Supp. 1033 (E.D.N.Y. 1984).

8. Id., at 268-69. See also, Bowen v. Michigan Academy of Family Physicians, 476 U.S. 667 (1986); Kraemer v. Heckler, 737 F.2d 214 (2nd Cir. 1984).

9. Gray Panthers v. Schweiker, 652 F.2d 146, 161-162 (D.C.Cir. 1986) (Gray Panthers I). The court reiterated this position in Gray Panthers II, 716 F.2d 23 (D.C.Cir. 1993), at 28.

pre-termination review. As the Court noted in Goldberg, "termination of aid pending resolution of a controversy over eligibility may deprive an eligible recipient of the very means by which to live while he waits."[10] Unfortunately, with respect to the Medicare program, pre-termination review as a legal concept is not uniformly developed. Pre-termination review, however, has been recognized to some extent in the areas of Medicare covered home health, and skilled nursing facility (SNF) care, and hospital care.[11] Even there, the precise nature and scope of pre-termination review is not established.

The Supreme Court, in Morrissey v. Brewer, noted, "[D]ue process is flexible and calls for such procedural protections as the particular situation demands."[12] In Matthews v. Eldridge, the Supreme Court established a three-pronged balancing test for evaluating whether a hearing procedure meets due process standards for Social Security Act cases:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.[13]

Medicare hearing rights are codified at 42 U.S.C. §1395ff. The Hearing is to provide the same procedural rights as provided to Social Security Title II beneficiaries. 42 U.S.C. §1395ff(b)(1). Title II hearing rights, including review in the federal district courts, codified at 42 U.S.C. §405(b)-(g), require reasonable

---

[10]. 397 U.S. at 264.

[11]. See, Martinez v. Sullivan, 874 F.2d 751 (10th Cir. 1989); Kraemer v. Heckler, 737 F.2d 214 (2d Cir. 1984); Martinez v. Richardson, 472 F.2d 1121 (10th Cir. 1972); Martinez v. Bowen, 655 F. Supp. 95 (D.N.M. 1986). See also, Sarrassat v. Sullivan, (N.D. Calif. 1989) [1990] Medicare and Medicaid Guide, ¶38,504)(Skilled nursing facilities must use uniform denial notices to inform residents of their right to request facilities to submit claims to the intermediary for initial decision. The notice must also state that a facility cannot bill the resident until the intermediary makes a formal determination).

[12]. Morrissey v. Brewer, 408 U.S. 471, 481.

[13]. Matthews v. Eldridge, 424 U.S. 319, 334-35.

notice and opportunity for a hearing. These hearings are non-adversarial.[14] Attorneys fees are available pursuant to 42 U.S.C §405(g) and through the Equal Access to Justice Act (EAJA), 42 U.S.C. §2412 et seq., (federal district court review).

Medicare beneficiary hearing and appeals rights are further defined in 42 C.F.R. §405, Subpart G (Reconsiderations and Appeals Under Medicare Part A); 42 C.F.R. §473, Subpart B (Peer Review Organizations Reconsiderations and Appeals); 42 C.F.R. §405, Subpart H (Review and Hearing Under the Supplementary Medical Insurance Program -- Part B); 42 C.F.R. §417, Subpart C (HMO/CMP Beneficiary Appeals). While these appeals procedures vary in specifics, they all include, at a minimum: (1) an initial review and/or "reconsideration" by the original decision-making entity or someone else; (2) review in the form of a hearing before an independent hearing officer; and (3) recourse to the judicial system if a threshold amount of money remains in controversy. Medicare beneficiaries who have been successful in judicial appeals can recover their attorneys' fees under two provisions of the law.[13]

Circumstances requiring expedited appeals are illustrated by the Peer Review Organization (or PRO) hearing procedures. These apply, for example, when a Medicare beneficiary is a hospital inpatient and the doctor and hospital agree that the patient should be discharged. If the patient requests PRO review before noon of the first working day after the denial notice was delivered to the inpatient, then the hospital must provide the patient's record to the PRO by the close of that first working day. The PRO must issue a review decision within one full working day after the date the PRO received the review request and the records. In such cases, the hospital may not charge the patient for any charges incurred before noon of the day following the day on which the PRO review decision is received by the patient. If the patient is still dissatisfied with the decision, the regular process of reconsideration, hearing, and judicial review remain available.

Due process rights have been the subject of beneficiary litigation involving HMOs. For example, Medicare beneficiaries who use HMOs have claimed that they have been denied due process because HMO appeals procedures were not clearly defined and made known to them. Problems have included the lack of notice or a clearly defined procedure for review (including timely review by the HMO and access to external review such as Administrative Law

---

[14]. See, e.g., Richardson v. Perales, 402 U.S. 389, 403 (1971).

[13]. 42 U.S.C. §405(g) (concerning judicial review of the Secretary's decisions under the Social Security Act); and the Equal Access to Justice Act, 28 U.S.C. §2412.

Judge and court review).[14] Empirical studies of Medicare HMO operations by the General Accounting Office and Medicare advocacy groups have confirmed the existence of substantial problems in claims approval and payment, processing beneficiary appeals, and quality assurance systems.[15]

Experience with statutory changes in Medicare Part B appeals highlights the need for Congress to act with clarity in writing review and adjudicatory rights into statutes. In extending Part B benefits to Medicare beneficiaries in the Omnibus Budget Reconciliation Act of 1986, Congress did not make explicit the procedural steps leading to administrative law judge review.[16] This resulted in additional layers of claims review and considerable delays in obtaining relief for beneficiaries. The experience further led to Congressional studies of the problems created and to protracted litigation.[17]

B. Medicaid Hearing Rights

Medicaid hearing rights are found in federal law at 42 U.S.C. §1396a(a)(3) and in the regulations at 42 C.F.R. §431, Subpart E, as mandated by Goldberg v. Kelly and its progeny.[18] They include an opportunity for an appeal of any action or inaction harmful to the Medicaid beneficiary. Notice and hearing protections are triggered by a broad range of adverse actions, including denials of

---

[14]. See, e.g., Levy v. Sullivan, (C.D. Calif. 1989) [1989-2] Medicare and Medicaid Guide ¶37,809 (Settlement calling for the processing of HMO reconsideration requests pursuant to a 30-day timeliness standard and the issuance of a new HMO manual setting out a 30-60 day standard for the HMO stage of reconsideration decision-making.)

[15]. General Accounting Office, HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards, HRD-92-11 (November 12, 1991); Medicare Advocacy Project, Inc., Medicare Risk-Contract HMOs in California: A Study of Marketing, Quality, and Due Process Rights (January 1993); E. Hallowell, Challenging the HMO System of Incentives. Philadelphia Inquirer, (March 28, 1989).

[16]. Omnibus Budget Reconciliation Act of 1986, §9341, codified at 42 U.S.C. §1395ff

[17]. See, Isaacs v. Bowen, 865 F.2d 468 (2nd Cir. 1989); Abbey v. Sullivan, 785 F.Supp. 165 (S.D. N.Y. 1992).

[18]. Goldberg, supra note 2.

eligibility [19] or services;[20] claim denials for "technical reasons," such as form errors;[21] and imposition of copayments.[22] Related rights include the requirements that the agency issue and publicize its hearing procedures; that applicants and recipients receive notice of an adverse agency action, generally in advance of the action (with aid and services continued pending the appeal); and that applicants and recipients have the right to see case files, to review documents used by the state, to present witnesses, to cross-examine adverse witnesses, and to receive a decision on the record within a specified time.

Medicaid recipients must receive notice from the Medicaid agency of provider claims that have been denied. The agency must provide recipients with written certification that they are not liable for denied claims,[23] and recipients are entitled to limited notice and hearing rights regarding denied provider claims.[24]

Under Medicaid, consumers may sue in federal court to vindicate their rights, without jurisdictional dollar minimums.[25] Attorneys' fees and experts' fees are available to consumers who prevail.[26] Jurisdiction is also available in many state courts.[27]

C. ERISA Consumer Experience

ERISA was enacted to safeguard the rights of workers and beneficiaries in employee benefit plans, including employer provider health insurance. Nonetheless, the protections available under ERISA are much less extensive than those available under Medicare and Medicaid. In fact, in some instances the limited appeals provisions of ERISA actually cause harm to individuals.

---

19. See, e.g., Phillips v. Noot, 728 F.2d 1175 (8th Cir. 1984).

20. See, e.g., Eder v. Beal, 609 F.2d 1175 (8th Cir. 1984).

21. See, e.g., Easley v. Arkansas Dep't of Human Services, 645 F. Supp. 1535 (E.D. Ark. 1986).

22. See, e.g., Claus v. Smith, 519 F. Supp. 829 (N.D. Ind. 1981); Becker v. Blum, 464 F. Supp. 152, 155-57, 156-57 n. 5 (S.D.N.Y. 1978).

23. Easley v. Arkansas Depart. of Human Services, 645 F. Supp. 1535 (E.D. Ark. 1986).

24. Daniels v. Tennessee Depart of Health and Environment, (M.D. Tenn. 1985)[1985] Medicare and Medicaid Guide, ¶34,562.

25. 42 U.S.C. §1988; and see also, Suter v. Artist M., 112 S.Ct. 1360, 60 U.S.L.W. 4251 (March 25, 1992), raising questions about the standing of consumers under current law.

26. 42 U.S.C. §1988.

27. One example of a discrete issue in the Medicaid program is Medicaid estate recoveries. Numerous state court decisions have shaped the development of this law. See, e.g., Estate of Burke, 443 N.Y.S.2d 1003, 111 Misc. 2d 196 (N.Y. Surr. Ct. 1981), aff'd,

ERISA explicitly provides that "disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of [employee benefit] plans."[28] The disclosure provisions are especially important for participants and beneficiaries in employer-sponsored group health plans. The required disclosure documents explain eligibility to participate in health plans, coverage amounts, co-payments and deductibles, and describe grievance and appeal rights. Congress felt so strongly about the need to provide information to participants and beneficiaries that it established a cause of action and penalty for plan administrators who fail to comply with a request for documents within thirty days.[29]

In addition to the disclosure requirements, ERISA and its implementing regulations and case law establish a notice and review process for any participant or beneficiary whose claim for benefits has been denied.[30] Adequate written notice must be provided in language calculated to be understood. The notice must contain the specific reasons for the denial, reference to the health plan provisions upon which the denial is based, a description of any additional information needed to perfect the claim and the reasons why the information is necessary, and an explanation of the steps for submitting the claim for review.[31]

Failure to comply with the notice provisions can result in liability to the health plan. Thus, a health maintenance organization whose notice did not adequately inform the participant of the reasons for denial of coverage and of the need to obtain a second opinion was required to reimburse the participant for the medical expenses he incurred.[32] A plan whose denial notice was not specific enough about reasons for the denial of benefits and about the appeals process could not claim that the participant's appeal was untimely filed, and was required to pay the participant's attorneys fees.[33]

---

57 N.Y.S.2d 382, 456 N.Y.S.2d 716 (1982); In re Estate of Hanson, 451 N.W.2d 364 (Minn. Ct. App. 1990); Shelton v. Fresno Community Hosp., 174 Cal. App. 3d 39, 219 Cal. Rptr. 722 (1985).

28. 29 U.S.C. §1001(a).

29. 29 U.S.C. §§1132(a)(1)(A), (c).

30. 29 U.S.C. §1133.

31. 29 C.F.R. §2560.503-1(f).

32. Bellanger v. Health Plan of Nevada, 814 F.Supp. 918 (D.Nev. 1993).

33. White v. Jacobs Engineering Group, 896 F.2d 334 (9th Cir. 1989).

Participants whose claims have been denied must be given a reasonable opportunity for a "full and fair review by the appropriate named fiduciary of the decision denying the claim."[34] Although ERISA does not require claimants to pursue remedies through the plan's internal appeals procedure, courts have established a federal common law requirement that participants exhaust plan remedies before going to court.[35] An exception may be made and exhaustion not required in cases where serious procedural violations are shown or where exhaustion would be futile.[36]

Each health plan must establish a time period during which a claimant may file a request for review of a denied claim. Department of Labor regulations require that decisions on review be made "promptly," generally within 60 days. Plans may extend the time period for response to 120 days after receipt of the request for review if there are special circumstances, such as the need to hold a hearing or to wait for a meeting of the board of trustees. A request for review that is not acted upon within 120 days is deemed to be denied, and the claimant may seek judicial review.[37]

Participants and beneficiaries have hurt by the restrictions in the ERISA claims procedure. Unfortunately, many plans do not comply with the regulatory time frames, and some do not respond to requests for review. Claimants who have received inadequate notice concerning the appeals procedure have literally spent years waiting for the plan to act on their appeals.

The Department of Labor regulatory time frame also is problematic. A health plan participant can be made to wait four months for a decision whether a plan will cover needed medical treatment, thus delaying the treatment or the payment of expenses already incurred. There is no provision for expedited review in emergency situations; the most that the claimant can hope for is that a court will agree to waive the exhaustion requirement. Finally, too many plans view the claims procedure as a rubber stamp of the initial determination. There may be no independent evaluation of the dispute; the review is performed by the same person who made the initial determination.

Unlike Medicaid, and unlike Medicare to a certain extent, there is no right under ERISA to pre-termination review. Coverage under a private employer-sponsored group health plan is not an entitlement. Nothing in ERISA requires employers to offer health insurance to their employees and retirees, or to continue providing benefits at a constant level of coverage. Rather, ERISA gives employers and plan sponsors flexibility to create, alter, or terminate a health plan. Courts have cited the voluntary nature of ERISA health plans in upholding the right of plan sponsors to reduce coverage for a specific illness such as AIDS.[38] If,

---

[34]. 29 U.S.C. §1133(2).

[35]. See, e.g., Amato v. Bernard, 618 F.2d 559 (9th Cir. 1980).

[36]. See, e.g., Schwartz v. Interfaith Medical Center, 715 F.Supp. 1190 (E.D.N.Y. 1989); Gavalik v. Continental Can Co., 812 F.2d 834 (3d Cir. 1987).

[37]. 29 C.F.R. §2560.530-1.

[38]. McGann v. H & H Music, 946 F.2d 401 (5th Cir. 1991); Owens v. Storehouse, 984 F.2d 394 (11th Cir. 1993).

however, an employer has promised employees or retirees a specific level of benefits or benefits for a specific amount of time, courts may under a contract analysis require the employer to provide the health benefits that were promised.[39] While the court case is pending, however, the claimant is not entitled to the medical benefits in question.

An on-going case exemplifies the difficulties with ERISA. An insurance company notified a beneficiary, who uses both a gastrostomy tube and a jejunal tube, that it would no longer cover the nursing services he requires in order to reside at home. Coverage will terminate before the ERISA appeals process is complete, and there is no requirement that benefits continue pending appeal. Thus, even if the beneficiary receives a favorable decision from the claims process, his condition may deteriorate so much during the period in which his nursing needs are not covered that he will be forced into a nursing home anyway.

III. CONSTITUTIONAL UNDERPINNINGS OF HEALTH CARE ACCESS AND DUE PROCESS

A review of the constitutional underpinnings of health care access starts with the question of whether a "fundamental right" to health care exists in this country. This question is at the heart of constitutional equal protection analysis. As will be shown below, the absence of a firm positive answer to the fundamental right/equal protection question shifts the epicenter of constitutional analysis to the principles of procedural due process under the Fifth and Fourteenth Amendments.

A. A "Fundamental Right" To Health Care?

Legal commentators have frequently acknowledged the sad fact that the United States Constitution neither mandates nor creates a general or universally applicable "fundamental" right to health care.[40] Such a right has been recognized only in circumstances involving incarceration or commitment. For example, courts have reasoned that to put someone in prison where he or she is stripped of the ability to have access to care, and subsequently not to provide care, can result in "cruel and unusual" punishment which the Eighth Amendment prohibits. Inmates, therefore, have a right to care, and correctional officials have a duty to provide care that does not manifest a "deliberate indifference to the serious medical needs" of inmates.[41] Similarly, persons with mental retardation who are involuntarily committed possess a constitutional right to liberty, which includes rights to adequate food, shelter, clothing, and medical care:

---

[39]. See, e.g., International Union v. Yardman, 716 F.2d 1476 (6th Cir. 1983); Owens v. Storehouse, supra at 398.

[40]. See, e.g., Nancy N. Dubler & Charles P. Sabatino, "Age-Based Rationing and the Law: An Exploration," in Too Old For Health Care? - Controversies in Medicine, Law, Economics, and Ethics (Robert H. Binstock & Stephen G. Post eds., 1991).

[41]. Estelle v. Gamble, 429. U.S. 97,106 (1976).

> When a person is institutionalized-- and wholly dependent on the State(,] ... a duty to provide certain services and care does exit.[42]

The Supreme Court has refrained from explicitly recognizing a general right to treatment for all institutionalized persons. However, numerous lower courts and state legislatures have formalized this basic entitlement.[43] For the public at large, however, the lack of a recognized fundamental right to health care virtually eliminates a key constitutional avenue in advocacy for health care-- that of "equal protection."

B. Equal Protection Analysis

The Fourteenth Amendment provides that "no State shall ... deny to any person within its jurisdiction the equal protection of the laws." While this clause is not applicable to the federal government, it has been held that most acts by the federal government that would deny equal protection constitute a "deprivation of liberty" within the Fifth Amendment's due process clause.[44]

Generally, equal protection analysis has been used to determine the validity of classifications used in legislation. Most legislation imposes responsibilities on, or grants or denies benefits to, some classes of people-- whether they be taxpayers, parents, sport fishermen, pickle producers, employees, older persons, low income persons, high income persons, able bodied persons, or persons with disabilities. Normally, any such classifications will be upheld by the courts if "rationally related" to a proper state interest.[45] This test is highly deferential to legislative discretion. However, a higher standard -- a "strict scrutiny" test -- will apply if either of two conditions are met: (a) the legislative classification interferes with the exercise of a fundamental right, or (b) the classification operates to the particular disadvantage of a "suspect class".[46] Under this more rigorous test, a classification will be held to violate equal protection unless found to be necessary to promote a "compelling" state interest. Challenges to legislative classifications have a relatively high likelihood of success under the strict scrutiny test. While some justices have argued regularly for intermediate versions of this test, the dichotomous approach remains the official analytic approach of the Supreme Court. A right of the public at large cannot, of course, rely on a "suspect class" claim. Consequently, the non-recognition of a fundamental right to health care extinguishes viable constitutional claims based on equal protection.

Despite the lack of a general and legally enforceable right to health care in the United States, there may be some notion of a "right to life-sustaining care," based, paradoxically, on two growing bodies of cases: one establishing the right to refuse

---

[42]. Youngberg v. Romero, 457 U.S. 307, 317 (1982); see also, DeShaney v. Winnebago County Department of Social Services, 139 489 U.S. 189 (1989).

[43]. Barbara A. Weiner, "Treatment Rights," in The Mentally Disabled and the Law (S.J. Brakel, J. Parry, & B.A. Weiner, 1985).

[44]. Bolling v. Sharpe, 347 U.S. 497 (1954).

[45]. Ronald D. Rotunda, et al., 2 Treatise on Constitutional Law: Substantive and Procedure, (1986).

[46]. See, e.g., Massachusetts Board of Retirement v. Murgia, 427 U.S. 307, 312 (1976).

life-sustaining treatment or a so-called "right to die,"[47] and the other addressing the concept of a "right to life," first popularized in the abortion debate. These lines of cases acknowledge a state's "interest in the protection and preservation of human life" in the case of treatment refusals,[48] and the state's "interest in protecting potential human life" in the abortion cases.[49] The policy consequences of these two lines of cases have led some commentators to conclude, wryly, that the federal government is interested in children "from conception to birth" and in adults "from sickness to death," but only if life itself is imperiled.

Unfortunately, even within these limited contexts, the existence of a state interest in protecting and preserving human life has not led to the recognition of a fundamental constitutional right to life-sustaining health care. Therefore, equal protection analysis in this context ultimately fails. Instead, these cases focus on an analytically different but related constitutional principle, that of procedural "due process" under the Fifth and Fourteenth Amendments.

C. Procedural Due Process Analysis - The Constitutional Cornerstone

Applied to the federal and state governments, respectively, the Fifth and Fourteenth Amendments mandate that no person shall be deprived "of life, liberty, or property, without due process of law." As stated earlier, equal protection analysis is used to determine the constitutional validity of legislative classifications. In contrast, due process analysis is most relevant in adjudicating alleged deprivations of existing property or liberty interests. Of key importance is the fact that the existing liberty or property interests do not have to be constitutionally created. They may be rights created by statute or those recognized in the common law.

The due process clause is essentially a "limitation on the State's power to act."[50] It was intended to secure the individual from the arbitrary exercise of the powers of government and to prevent "unwarranted government interference,"[51] but it does not create an affirmative general obligation upon the government to provide any particular form of aid. The Supreme Court has been quite clear on this point, particularly in abortion cases, most recently reaffirming this proposition in Webster v. Missouri where it stated:

---

[47]. The line of cases starting with In re Quinlan, 355 A.2d 64, 70 N.J. 10 (1976), cert. denied, 454 U.S. 858 (1976) eventually led to the U.S. Supreme Court's first decision on the right to refuse life-sustaining treatment in Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990).

[48]. Cruzan, supra note 47, at 261.

[49]. Webster v. Missouri, 492 U.S. 490, 519 (1989).

[50]. DeShaney v. Winnebago County Department of Social Services, 489 U.S. 189, 195 (1989).

[51]. Id., at 196; see also, Parratt v.Taylor, 451 U.S. 527, 549 (1981).

> ...the Due Process Clauses generally confer no affirmative right to government aid, even where such aid may be necessary to secure life, liberty or property interests of which the government may not deprive the individual.[52]

The Court applied similar reasoning in a case contemporaneous to Webster, holding that the due process clause imposed no duty on the state of Wisconsin to provide adequate child protective services.[53]

Even though the due process clause provides no affirmative assurance of health care access, its procedural implications are, nevertheless, extremely significant for any national system of health care in two respects. First, to the extent that health reform legislation creates or controls statutory entitlements to benefits, procedural due process protections against deprivations of these benefits will apply. Statutory entitlement to a benefit is a property interest to which due process rights attach.[54] For example, state statutes establishing Medicaid and other indigent care programs have been held to engender property interests protected under procedural due process.[55]

Second, any rationing of care under such a system will likewise be scrutinized under principles of due process, since rationing may be functionally equivalent to a deprivation for those groups adversely affected. The following sections examine the nature and extent of procedural protections that may be constitutionally necessary in any government mandated or sponsored universal health care system. The rationing of health care is not addressed in this paper.

IV. QUALITY ASSURANCE AND CONSUMER PROTECTION

The duty to provide an adequate level of quality in the provision of health care is deeply rooted both in common law principles of tort and contract and in manifold state and federal administrative laws regulating health care providers. For certain vulnerable populations, such as those involuntarily

---

[52]. Webster, supra note 49, 492 U.S. at 507; see also, Harris v. McRae, 448 U.S. 297, 316 (1980), in which the Court said: "Regardless of whether the freedom of a woman to choose to terminate her pregnancy for health reasons lies at the core or the periphery of the due process liberty recognized in Roe v. Wade, 410 U.S. 113 (1973), it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices."

[53]. DeShaney, supra note 50.

[54]. See, e. g., Atkins v. Parker, 472 U.S. 115 (1985); Logan v. Zimmerman Brush Co., 455 U.S. 422 (1982).

[55]. See, e.g., Daniels v. Woodbury County, 742 F.2d 1128 (8th Cir. 1984); Griffeth v. Detrich, 603 F.2d 118 (9th Cir. 1979); Eder v. Beal, supra; Kimble v. Solomon, 599 F.2d 599 (4th Cir. 1979); Jones v. Blinziner, 536 F. Supp. 1189 (N.D. Ind. 1982).

institutionalized, poor quality of care may also result in a deprivations of a patient's constitutional rights.[56]

All states license individual and institutional health care providers, setting standards for practice and services. States commonly set additional standards for state-funded health and long-term care services. On top of all this, Medicare and Medicaid set extensive standards, primarily through "conditions of participation," on all participating providers.[57]

The central role of the individual with respect to his or her own health care is rooted in the common law right of self determination. In the oft-quoted 1914 case of Schloendorff v. N.Y. Hospital, Justice Cardozo succinctly articulates this right:

> Every human being of adult years and sound mind has the right to determine what shall be done with his own body.[58]

The other common law root of consumer control arises from the common law offense of battery which made any offensive, unwanted touching an actionable wrong. From this common law action evolved the right of "informed consent" and the corollary right to refuse treatment. A constitutional basis for personal control over health decisions is now well established in a substantial line of cases from the 1976 Karen Ann Quinlan (recognizing a privacy interest)[59] decision to the Supreme Court's opinion in Cruzan v. Director, Missouri Department of Health (recognizing a liberty interest).[60]

From these foundations has developed a body of patient/client rights and protections concepts that have been articulated most extensively in the area of nursing home care pursuant to the 1987 nursing home reform amendments.[61] While the depth and breadth and detail of these rights is specific to a targeted, highly vulnerable group of patients, they are, nevertheless, instructive as a high water mark of patient/client rights and as an affirmation of basic consumer protection elements establishing: the right to notice and information necessary to make informed decisions; the right to protections against abuse; the right to complain through effective grievance mechanisms without fear of retaliation; and the right to personal preferences and privacy.

---

[56]. Estelle v. Gamble, supra note 41; Youngberg v. Romero, supra note 42, 457 U.S. at 317.

[57]. See, generally, Medicare & Medicaid Guide, ¶12,305 (CCH).

[58]. Schloendorff v. Society of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914).

[59]. In re Quinlan, 355 A.2d 647, cert. denied sub nom. Garger v. New Jersey, 429 U.S. 922 (1976).

[60]. Cruzan, supra note 47.

[61]. Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. No. 100-203, Title IV, Subtitle C, §§4201-4206, 4211-4216, 42 U.S.C. §§1395i-3(a)-(h), 1396r(a)-(h), Medicare and Medicaid, respectively.

V. The Administrative Procedures Act (APA) (5 U.S.C. §§554-557)

The formal adjudication sections of the APA apply to cases which by statute must be reviewed on the record after a hearing. While not directly applying to Medicare or Medicaid beneficiary appeals, these adjudicatory sections, consistent with constitutional norms of due process, provide the following:

1. A clear statement (notice) of the right to a hearing. Generally, this includes a statement that a hearing is available, the applicable time periods for requesting the hearings, and the steps necessary to obtain that hearing. §554(b).

2. An opportunity to participate in the hearing. This includes the right to be physically present at the hearing. §554(c).

3. An opportunity to appear before an impartial hearing officer. The hearing officer should be free to make an independent judgment of the facts at issue. §554(d) and 556(b).

4. The right of parties to be represented by counsel at hearings. Parties should be free to have either a lawyer or other representative present at hearings. §555(b).

5. The right to present oral and written evidence and to conduct cross-examination. This includes the right to see and examine all relevant documents prior to the hearing. §556(d).

6. The right to submit proposed findings of fact, conclusions of law, or to note exceptions. This includes the right of parties to submit oral and written legal arguments in support of their respective positions. §557(c).

7. The right to a written record or transcript of the hearing. This includes the right to have access to the transcript of the proceedings in a timely fashion and at affordable costs. §556(3).

Coalition for Consumer Protection and Quality in Health Care Reform

White Paper on

Minimum Requirements for Consumer Information

Introduction

Consumer information is an important dimension in any reform of the health care system, whether the reform is based on managed competition or a single payer system. Managed competition assumes that well-informed consumers will stimulate plans to provide high quality care at low costs. Under a single payer system, consumer information is important for much the same reason—information about practitioners and providers allows consumers to shop for the best care at reasonable prices. For this to happen, consumers must have access to comprehensive, uniform and comparable information. Under either type of reform, the data collected by the health plans must be verified on an ongoing basis by state entities independent of the health plans, health alliances or other purchasers of care.

A national entity such as a National Health Board should be responsible for 1) establishing uniform data formats, 2) setting standards for collecting and analyzing data and 3) distributing the data on the national, state and plan levels. It is essential that the data and information be accurate, reliable, comparable, timely, and easy-to-understand. It must also be available in different languages and formats for people with special challenges such as the visually or hearing impaired.

With the increase of data collection and dissemination through the electronic media, the protection of consumer confidentiality becomes increasingly important. National standards should be established to protect consumers from unauthorized disclosure of any personal and individually identifiable information.

We want to make it clear, however, that even good consumer information will not eliminate the need for appropriate grievance and appeals procedures, internal and external quality assurance and external, independent quality oversight and monitoring of the health care system.

Summary

We believe that information available to consumers must be more than a "report card." A more appropriate description for what is needed is a "Consumer Guidebook" for plan selection and use. National standards should mandate what specific information will be provided in this guidebook, which should be readily available to every consumer.

The data should also be utilized to assist health care professionals in providing appropriate and effective care and to enable policy makers to fine tune the system to increase quality and reduce costs.

We envision four main categories of information:

1) plan-specific descriptions including general information about the health alliance, the health care system and where to get help

2) plan-specific quality report cards—quality indicators reflecting a common set of performance measures and enrollee satisfaction

3) provider and practitioner-specific descriptions to help discriminating consumers choose a plan based on the background of specific practitioners or services of a hospital

4) condition-specific provider and practitioner quality report cards to help guide the consumer to the best specialist or the best hospital for treatment of a specific condition.

1) Plan-Specific Description Information

If consumers are going to make informed choices, they need good understandable information describing plan configurations, how the health care delivery system works, how to use the consumer guide, how to appeal a health care decision, how to resolve complaints, and how to contact a health ombudsprogram or counseling program. Next, they will need to know the prices, benefits, and services of each plan option. The goal is to enable the consumer to compare health care plans in a given health alliance. The information should include descriptive and practical summaries presented in a comparative format.

Price, benefit and plan operation information could include:

Price Information for individuals and families:

- premiums, deductibles and co-payments
- cost or implications of using services outside the plan
- cost of coverage beyond the basic plan
- premium increase trend

Benefits, Plan Description and Policies:

- benefits covered
- services not covered by the plan
- time in operation
- membership size and percent in certain age groups
- number of practitioners and their areas of specialization
- ratio of membership to primary care physicians
- ratio of physician to non-physician primary care practitioners
- specialists available within the plan; outside the plan
- ratio of board certified physicians to non-board certified
- names of participating hospitals, home health agencies, laboratories, diagnostic facilities, pharmacies
- contractual relations between plans and providers
- plan policy regarding scheduling of routine annual physical exams, pre-natal visits, well-baby visits, immunizations
- plan policy regarding promptness of access for evaluation of symptoms
- plan policy regarding urgent care, hospitalization, length of hospital stays, specialist referrals, diagnostic procedures, mental health services, laboratory services, home health services, prescriptions
- plan policy regarding care management and long-term care

- plan policy regarding second and third opinions
- phone numbers for information specialists who can explain plan details

2) Plan-Specific Quality Report Cards—quality indicators reflecting a common set of performance measures and enrollee satisfaction surveys

The "report card" or quality measures and consumer satisfaction section of the consumer guidebook should compare the plans, providers, and practitioners in a given health alliance and, when appropriate, provide national averages for comparison. Areas that should be covered include enrollee access to care, quality of care, appropriate use of medical care, utilization rates, and the effectiveness of specific treatments and patient outcomes by diagnosis or procedure. Information about where to get assistance in interpreting the information and data should be provided to the consumer.

Performance Measures

Use of a common set of performance measures will not only provide consumers with good decision-making information, it will also enable health plans and providers to identify the best practices. The national health board created to oversee the new health care system should also use the quality measures in the development and dissemination of clinical practice guidelines, the updating of the benefit packages, and the analysis of the cost-effectiveness of the health care provided.

It is expected that quality and its indicators will improve and evolve based on information from outcomes research. Required reporting of patient care encounters (presenting problem, diagnosis and treatment), and uniform patient identifiers to allow longitudinal records, should be considered. In addition, reporting of complications and hospital acquired injuries in the clinical record should be required. Clinical information will provide far more useful data than data extracted from billing codes (notably not available from managed care programs). Outcomes research studies should be conducted to evaluate patients' health status after specific treatments, including physiological measurements, functional status, and well-being/quality of life. This information should be made available to consumers, providers, and policy makers. These measures are essential for competition to succeed in improving and/or maintaining quality of health services.

The following types of information could be included in this section of the guidebook:

Preventive Care

Percentage of enrollees of certain age groups for whom appropriately timed preventive measures were provided or recommended, such as:

- health history interview and record
- annual physical and functional status assessment; urinalysis; blood hemoglobin, cholesterol (adult)
- childhood immunizations and boosters
- seniors: flu vaccination annually; pneumococcal vaccination one-time; boosters for tetanus and diphteria
- hepatitis b vaccine (for those with high exposure risk)
- tuberculosis screening
- colorectal screening

- mammogram screening
- gynecological exam and Pap smear annually (adult and/or sexually active females)
- prenatal care during 1st, 2nd, 3rd trimesters
- routine eye exams for seniors and diabetics

Indicators of undesired or unplanned occurrences, such as:

- inappropriate use of medications
- re-admissions within 30 days of post-surgery hospital discharge
- location-of-service acquired infections
- pressure ulcers occurring in patients confined to bed.
- injuries sustained at location-of-service: e.g., fractures, muscle contractures, harmful medication and treatment errors

Utilization of services related to service policy, such as:

- average time between first report of acute illness and examination
- average time between diagnosis and treatment of acute illness
- percent follow-up visit or phone call after acute illness
- average length of hospital stay: surgery, normal delivery, C-section, rehabilitation, mental health acute care
- number of referrals to specialists per primary practitioner
- number of referrals for diagnostic procedures
- average time between diagnosis and various kinds of elective procedures

Consumer Satisfaction

A standard survey should be developed that will measure satisfaction among health plan participants. It could have some regional or otherwise appropriate individualized characteristics, but the main body of the survey should be consistent across the country so that it can be used for national comparisons. The survey should be short and clear and contain questions related to acceptability, availability and accessibility. It could include:

- overall satisfaction with care received
- degree to which questions were answered
- adequacy of treatment information
- did treatment alleviate symptoms
- convenience of location of doctors and hospitals
- number of specialists from which to choose
- number of primary care physicians from which to choose
- ease of obtaining desired referral
- degree to which plan follows through on referrals to medical services
- attitude of staff and of physician
- length of time between making appointment and visit for symptoms or for preventive care
- length of time "on hold" before getting through to the plan
- length of time spent in the waiting room
- length of time spent with practitioner
- length of time between diagnosis and treatment
- availability of advice over the phone
- excessive paperwork or bureaucratic hassles
- willingness to recommend this plan to a friend

It should be mentioned that the New England Medical Center, Health Institute has developed an "Employee Health Care Value Survey" as part of the Health Plan Employer Data and Information Set, HEDIS, which looks promising.

Membership statistics

Membership statistics can also be indicative of consumer satisfaction and should be listed:

- number of new enrollees and dis-enrollees per year
- number of enrollee complaints

3) Provider and Practitioner-Specific Descriptive Information

Further details on plans and their health care professionals should be provided on a per request basis. For example, if a consumer is trying to decide between Plan A and Plan B, he or she may want to review the detailed plan descriptions, which would be written in a standardized format with the plan's unique features set apart from items that the plans must contain. Information such as fact sheets on each of the physicians in the plan, their training, years of practice, board certification, faculty responsibilities, and documented disciplinary actions, including repeated malpractice payments, should be provided in this documentation. Fact sheets about home health services, hospitals, laboratories and other contracted health facilities could also be developed. The health alliances or individual plans could supply this information under supervision and monitoring of the state quality assurance entity.

Hospitals

Types of services provided, bed capacity and nursing services staffing of each type of unit:

- emergency department
- intensive care unit
- cardiac care unit
- general medicine and specialty units
- rehabilitation therapies
- surgery general and specialties
- obstetrics: delivery room, birthing room, operative procedures
- newborn care: normal newborn and intensive care nurseries
- radiology treatment and diagnostic capacity
- laboratory
- social services and discharge planning

Home Health Services

- skilled nursing and rehabilitative care
- hospice care services
- personal care aides
- home care equipment (e.g. oxygen, suction, special beds)

Out-patient Services

- urgent care

- diagnostic and follow-up care
- pharmacy services
- laboratory services

Nursing home skilled care

- routine practitioner visits
- diagnostic services

4) Condition-Specific Provider and Practitioner Report Cards including Enrollee Surveys

Condition or treatment specific information is important to the person who faces a major operation or health care decision and should be available upon request. This information is different from the plan specific report card in that it includes both hospital and physician specific practice profiles and outcomes data on a particular procedure or condition.

For example, a consumer may want to know which hospital in the region (or the country) has the most experience in kidney transplants; which surgeon has the lowest mortality rate within that particular hospital or within a region; which hospital has the lowest mortality rate; which has the lowest post-surgery complication rates, and other factors. This is similar to what has been done for coronary artery bypass graft surgery in both Pennsylvania and New York. The information could be presented either on a nation-wide or a region-wide basis and could be available from the national health board or its designees. The data should be appropriately adjusted for severity to avoid skewing outcomes for surgeons and hospitals serving more vulnerable populations. Also, health counselors should be available for answering questions regarding this and other consumer information.

Information obtained through the enrollee satisfaction surveys which address condition-specific provider and practitioner quality and outcomes should also be available as part of this report card.

Confidentiality of Personal Information

With more emphasis on data collection and improved electronic data interchange, the risk of violating a person's right to privacy increases. Health care information often contains very personal information about physical and mental medical history, conditions and treatments.

The collection, storage, handling, and transmission of individually identifiable health care data should in no way infringe upon a person's right to privacy and to keep certain information confidential. National uniform standards should delineate very specifically what type of individually identifiable information may or may not be released without the person's authorization. Such standards should also delineate to whom confidential data may be released and for what purposes it may be used.

Conclusion

Consumer information must be developed with consumers' needs in mind and with active consumer participation. Information should be available in written, verbal and electronic forms, and in Braille and other languages to reach all populations. The success of health care reform is largely dependent on the ability of consumers to make wise choices and influence the quality and cost of health care. Therefore, the plan must

provide the consumer with the necessary tools for good decision-making. Consumers need to know which provider offers the best services at the least costs, which practitioners have the most success with which treatments, and which hospitals are most likely to send the patient home without further complication. They also need protection against misuse of their personal records; and information about how to file complaints, appeal decisions or get outside assistance by a health ombudsprogram or counselor. This will require resources, but it will cost a small fraction of the cost of not implementing an effective health care monitoring and reporting system from the start. Good information and decisions alone will not ensure quality care. Quality assurance measures, grievance and appeals procedures, and independent, external entities must be in place to monitor quality and enforce standards.

Statement

of the

Group Health Association of America

The Group Health Association of America (GHAA) is pleased to submit testimony on consumer protection to the Labor Subcommittee of the Senate Labor and Human Resources Committee of the U.S. Senate. GHAA represents 350 health maintenance organizations (HMOs) with 33 million members who account for about 75 percent of total HMO enrollment nationwide.

Background

HMOs provide integrated, coordinated, high-quality health care at predictable cost to consumers, who consistently give HMOs positive reviews. Consumers' positive attitudes towards HMOs are reflected in increasing enrollment and high renewal rates. HMO enrollment has quadrupled during the past decade alone. Today about 45 million people — roughly one out of every five Americans who have health insurance — are enrolled in HMOs, and GHAA estimates that HMO enrollment will exceed 50 million by the end of 1994. Many national surveys have found high levels of satisfaction among HMO members and studies consistently find equal or better satisfaction among consumers enrolled in managed care organizations when compared to those in the fee-for-service sector.[1]

Comprehensive Benefits

HMOs provide comprehnsive benefits, usually with no deductibles and with minimal copayments. HMOs emphasize preventive care services: 93 percent of HMO enrollees are covered for routine physical exams, compared to 43 percent of fee-for-service plan participants; more than 90 percent of HMO enrollees are in plans covering well baby care, compared to less than 60 percent of fee-for-service participants. HMO coverage for illness is similarly comprehensive: 90 percent of HMO enrollees are covered for skilled nursing and hospice care, for example, compared to 80 percent of fee-for-service participants.

---

[1]A Kaiser Family Foundation and the Commonwealth Fund study (December 1993) found that 85% of HMO members are either very satisfied or somewhat satisfied with their health care coverage. 87% of HMO members reported having a regular doctor, compared with 80% of non-members, and 83% of HMO members reported being satisfied with their choice of doctors, compared with 79% of non-members. Similar results were found by Novalis Corp in September 1993, the Boston Globe and Harvard School of Public Health the same month, and National Research Corp. and Consumer Reports in 1992.

Preventive and Primary Health Care
As part of their integrated approach to health care, HMOs offer a continuing program of preventive and primary health care services, for example comprehensive maternity and well-baby care, family planning and reproductive health services, smoking cessation, mammography screening, and case management practices that encourage early intervention. A Rand Corporation study published January 15, 1994, showed that HMOs were rated above the national average in the delivery of key prenatal services. All of these contribute to both quality and cost containment; indeed, improved quality of care and long-term cost containment are virtually inseparable in this context.

Quality Assessment and Improvement Systems
HMOs quality assessment and improvement systems include careful selection of well-qualified providers who will work well within a coordinated care system. Eighty-five percent of HMO physicians are board-certified, compared to 60 percent of physicians nationwide. And, unlike the fee-for-service sector, HMOs routinely monitor and analyze clinical practices and patient outcomes. They use this information to improve the quality and cost-effectiveness of care. Such high-quality, cost-effective care requires active coordination of services, active attention to detail, and active consumer education.

Current Protections for HMO Consumers

Consumers in HMOs have the benefit of a variety of consumer protections as a result of the integrated HMO delivery systems as well as public and private standards and regulations. The organizational structure of the HMO itself supplies protection because integrated, coordinated care is inherently more accountable than uncoordinated fee-for-service medicine. Each patient's primary care physician takes responsibility for coordinating needed care. If the patient is unsatisfied with his or her primary care physician, the patient may choose another. HMOs also have internal quality programs designed to identify and design strategies to address areas that can be improved. HMOs also have internal patient grievance procedures, which are a formal mechanism that allows patients to voice complaints about coverage or administrative procedures. Many HMOs now are being accredited by the independent National Committee for Quality Assurance, whose accreditation standards are strict. Finally, many state and federal agencies oversee HMOs. All told, this adds up to protection well beyond that available to most health care consumers.

Consumer Protection Under Reform

GHAA believes that the most important components of consumer protection under reform are national health plan standards and consumer choice. It is critical that all health plans meet uniform standards regardless of their structure and that consumers are offered a periodic choice among health plans to allow them to "vote with their feet" if dissatisfied with their plan.

National Health Plan Standards
We believe that national health care reform should include uniform, national standards for health plans as part of a strategy for protecting patients and providers. Without such standards, the regulatory climate will vary from state to state, potentially creating problems and uncertainties for consumers as well as for providers of care. In recognition of the importance of national standards, GHAA has been working with our member plans to develop health plan standards that we believe will provide a uniform level of protection for consumers throughout the United States. Key elements of these standards are described below. Full details are included as an attachment to this statement.

From a consumer protection standpoint, it is critical that all health plans meet uniform standards -- and this will become even more important as health care reform evolves. The standards apply to the full spectrum of health plans that offer coverages ranging from traditional HMO coverage to traditional indemnity coverage. Key elements of these standards are provided below.

Health care delivery system standards include requirements: that plans with delivery systems of participating providers provide access to all covered benefits; that enrollees have the opportunity to select a primary care physician of their choice within the plan and change physicians; and that service area boundaries are drawn in a nondiscriminatory manner.

Quality assurance system standards will require all plans with delivery systems to meet requirements for internal quality assurance and improvement systems. In addition, all health plans should report performance measures annually to allow consumers to compare and make informed choices among competing plans.

Patient privacy must be protected by all health plans. The standards provide that the confidentiality of patient-specific information must be maintained as required by applicable law.

Marketing standards for all health plans should include requirements that all plans must provide written descriptions of their benefits, services, and procedures that clearly and fully describe any and all limitations of coverage. All advertising materials must be factually accurate and must be responsive to the needs of diverse populations.

Administrative standards should ensure that enrollees and physicians are fully informed of plan policies and procedures. In addition, GHAA believes that established internal dispute resolution procedures should be available to enrollees, when disputes arise between health plans and enrollees.

Capitalization standards, based on standards developed by the National Association of Insurance Commissioners' Model HMO Act and NAIC insurance company standards, maximize the likelihood that all health plans will have the financial capability to provide promised health care benefits. Consumers must have confidence in the viability of the health plan serving them and must have protection against interruptions in continuity of care due to the failure of a plan.

Consumers must be protected in the event of insolvency. GHAA supports federal laws that mandate that health plan enrollees must be held harmless from incurring liability for the payment of any fees that are the legal obligation of the health plan.

Consumer Choice

Consumer choice also should be a key component of health care reform. GHAA and its member plans long have advocated that consumers be offered the right to consider a variety of health plans, including HMOs and other managed care plans as well as fee-for-service (FFS) plans. Furthermore, enrollees should be given periodic opportunities to consider alternative plans. Aside from the fact that consumers deserve this protection, it simply makes good sense to ensure that enrollment in HMOs is truly voluntary and firmly based on understanding how HMOs work.

Consumers have various HMO models to choose from. In staff or group model HMOs, physicians and outpatient services usually are provided in the HMO's own facilities. In independent practice association (IPA) model and network model HMOs, patients see physicians in their own offices. Increasingly, consumers also can choose plans offering a point-of-service (POS) option that allows them, at additional cost, to select unaffiliated physicians, although only a small percentage of HMO enrollees are currently enrolled under this option.

GHAA also supports the concept of "report cards" embodied in President Clinton's health plan to strengthen consumer choice. In cooperation with the independent National Committee for Quality Assurance, GHAA member plans have been working for some time on developing and refining such a system. Report cards will provide comparative information that will permit consumers to make informed choices among health plans.

The development and refinement of meaningful report cards requires standardized data collection and analysis, and it will take time for all plans to develop the capability to meet this need. But we are confident that within a few years report cards will become not only a major consumer education tool but will encourage competition among health plans on the basis of quality as well as price, an environment in which HMOs expect to do well.

Legal reforms

The different reform proposals that have been introduced contain a number of legal changes. Changes to the legal system that should be designed to benefit consumers and facilitate competition. Antitrust laws are designed to protect consumers by ensuring a sufficient level of market competition to maximize consumer choice, and to keep prices down and quality high. These laws have been critical to allowing innovation in the health care marketplace by preventing providers from working together to block the development of HMOs and other managed care organizations. Current antitrust policies allow ample opportunity for new provider-sponsored health plans and joint ventures without permitting monopolistic practices that would result in a less competitive environment. Therefore, GHAA strongly supports maintaining current antitrust protections and opposes new exemptions for such purposes as collective negotiations of fees by providers.

Conclusion

In conclusion, GHAA would like to reiterate our support for uniform, national standards for health plans and for a system that allows all consumers to choose between fee-for-service and managed care plans. We urge you to consider carefully the standards we have developed. Consumers are entitled to the peace of mind of knowing that all health plans are adequately capitalized and financially sound; that health plans are able to provide the full range of services that they commit themselves to offer; that quality of care is continually reviewed and enhanced; and that health plans have the freedom to select participating providers based on clearly established credentials, including providers' cost-effectiveness.

GHAA PROPOSED STANDARDS FOR HEALTH PLANS UNDER HEALTH CARE REFORM

A DISCUSSION PAPER

HEALTH CARE REFORM will significantly alter the environment in which health plans operate. The importance of developing fair, consistent performance standards cannot be overstated. In the absence of such standards, the regulatory climate will vary from state to state, creating problems and uncertainties for consumers as well as for providers of care. The purpose of this GHAA discussion paper is to advance the process of developing standards that will provide a uniform level of protection for consumers throughout the United States while simultaneously creating a level playing field for health plans.

INTRODUCTION

Although the outcome of the health care reform debate remains to be determined, there appears to be increasing agreement among policymakers that true reform requires adherence to certain key principles, including:

- *Universal coverage* within a specified timetable, to ensure that all Americans have comprehensive health care coverage and to mitigate against cost-shifting from the uninsured to the insured;
- *Insurance reforms* to ensure that all individuals have coverage regardless of their health status, including prohibition of waiting periods and pre-existing condition exclusions, and more equitable distribution of risk among insurance purchasers;
- *A standard benefits package* to ensure comprehensive coverage and to create a basis for containing future cost increases by promoting fair competition among health plans;
- *Freedom of choice* among competing health plans — and among competing *types* of health plans, including both managed-care and fee-for-service plans — to ensure that all consumers enroll voluntarily in the health plan of their choice and periodically have the opportunity to choose another plan.

Under President Clinton's and most other health care reform proposals, health maintenance organizations and other managed care organizations are expected to play a central role in providing superior health care to all Americans at broadly affordable cost. In light of the demonstrated ability of HMOs to deliver high-quality, cost-effective care, this emphasis on managed care is gratifying but not surprising. For reform to succeed, however, policymakers will need to develop health plan standards that eliminate regulatory inequities, so that all health plans can compete under consistent rules.

It is important to understand that 'managed care' is a phrase with multiple meanings. HMOs provide integrated financing and delivery of health care, coordinating care through a team approach; clinicians and administrators share responsibility for ensuring that all medically necessary care is made available to enrollees — whose individual care is coordinated by primary care physicians — within a predetermined overall budget. As such, HMO-style 'managed care,' with its emphasis on coordination of services and cost-effective preventive care, is distinctly different from traditional fee-for-service medicine, in which the sources of the financing and the delivery of health care are unconnected. Under conventional indemnity insurance coverage, fees accumulate as services accumulate, making care management and cost containment difficult.

Between these two poles of health care coverage are various hybrids. For example, preferred provider organizations (PPOs) create networks of providers who have agreed to accept negotiated fees, in some cases emphasizing the managing of costs more than the coordination of care. Similarly, physician-hospital organizations (PHOs) are creating networks of physicians and institutions that may become delivery systems for health plans or may form freestanding health plans.

From a consumer protection standpoint, it is important that all health plans meet uniform standards regardless of their structure — and this will become even more

important as health care reform evolves. Within the patchwork regulatory structure that governs the health care marketplace today, not all health plans are treated alike. Generally speaking, HMOs are the most stringently regulated, partly because they take responsibility for both financing and delivery of health care.

As a result, some health plans today are burdened by state anti-managed care laws that restrict their ability to choose providers selectively — in effect penalizing them for being concerned about providers' credentials and about suiting resources to the needs of their members. Some health plans are subject to stricter capitalization requirements than others. Some operate under marketing restrictions that may not apply to their competitors. The playing field, in short, is far from level.

This should be a matter of concern to all consumers of health care. Consumers are entitled to the peace of mind of knowing that all health plans are adequately capitalized and financially sound; that health plans are able to provide the full range of services that they commit themselves to offer; that physicians rather than administrators make all clinical decisions; that quality of care is continually reviewed and enhanced; and that health plans have the freedom to select participating providers based on clearly established credentials, including providers' cost-effectiveness.

Consumer confidence requires regulatory consistency. A reformed health care system that seeks to guarantee universal access to high-quality health services will be able to earn and maintain consumer confidence only if regulatory consistency is achieved nationwide. Similarly, the goal of bringing costs under control can be met only if regulatory standards promote and support fair competition. To meet the needs and expectations of consumers, and to achieve a level playing field for health plans, reform legislation and regulatory standards must meet several essential criteria:

- To establish consistent standards for all health plans nationwide, state laws that are inconsistent with the goals of national health care reform must be preempted.

- To ensure access to all covered services and to promote uniformly high-quality care, all health plans that offer health services coverage through participating providers must meet comparable delivery system requirements.

- To establish standards for fair marketing and protect consumers against the risk of insolvency, all health plans must meet consistent requirements for capitalization, financial soundness and fair marketing practices.

- To protect consumers and providers against arbitrary administrative actions, all health plans must clearly communicate procedures for obtaining covered services and must provide mechanisms for resolving disputes.

The proposed standards discussed on the following pages are intended to address these and related concerns. Developing and implementing standards to assure the success of health care reform is, of course, a dynamic process, and this document will necessarily evolve as reform gains momentum. Our intent is to encourage that process by offering criteria for reform that will protect all health care consumers and give all health plans an opportunity to compete fairly.

HEALTH CARE DELIVERY SYSTEM STANDARDS

Health plans offering coverage under which enrollees must obtain covered services (except emergency services) from participating providers, or offering coverage under which enrollees may obtain covered services from participating providers at their election, assume responsibility for the financing of health care as well as the delivery of all in-plan services. Consequently they should ensure that their delivery systems afford access to all covered benefits; ensure that decisions about how to provide services are made in the best interests of enrollees; ensure that enrollees have the opportunity to select a primary care physician of their choice within the plan and to change physicians at their election; ensure that all participating providers meet applicable licensure requirements; and ensure that service area boundaries are drawn in a nondiscriminatory manner.

Proposed Standards:

A health plan that provides services through participating providers must meet the following standards with respect to its delivery system:

1. The health plan must have an organized system of health care delivery that provides services through participating providers (including hospitals and other institutions). Providers must have agreed to accept an agreed-upon payment from the health plan as payment in full for services to the plan's enrollees (with the exception of enrollee cost sharing amounts established by the health plan).

2. The health plan must establish policies and procedures to ensure accessibility to and availability of all covered services for all enrolled members, including criteria for the selection of participating providers of the appropriate number and type and recognition of the needs of diverse populations.

3. The health plan must provide services in a manner that promotes appropriate patient care by establishing procedures to monitor the services provided and to continually improve the quality of care.

4. The health plan must establish policies and procedures that permit each patient to choose a personal physician from among the participating primary care physicians, and permit patients to change personal physicians.

5. The health plan must foster effective relationships between doctors, other clinicians and patients.

6. In accordance with quality assurance system standards, participating providers and facilities must be appropriately licensed, certified and/or accredited as required by applicable laws and regulations.

7. Health plans shall not discriminate in the drawing of service area boundaries on the basis of race, ethnicity, socio-economic status, age, or anticipated need for health services.

QUALITY ASSURANCE SYSTEM STANDARDS

Health plans that assume responsibility for providing health care services through participating providers should also accept responsibility for establishing systems to monitor and continually improve the quality of the care that their enrollees receive. Plans such as HMOs, which provide most covered services from within the plan, are able to continually assess the performance of their delivery systems and, based on this direct experience, to improve quality of care on an ongoing basis. This unique capability will enable them to play a leadership role in developing comparative quality-of-care measures to help consumers make more informed choices among competing plans.

All health care delivery systems should be required to meet the same stringent quality assurance criteria, and all health plans should report performance measures

annually in a manner that permits consumers to make comparisons among plans. Standards should also reflect the fact that existing quality assurance and performance measures are rapidly becoming more sophisticated, and should provide for continuing reliance on the capabilities of independent private-sector accrediting entities.

Health care reform offers an opportunity to improve on current oversight of quality assurance systems. For example, HMOs are now subject to multiple reviews based upon differing criteria. The staff and financial resources needed to respond to these reviews would be more wisely dedicated to internal quality improvement activities. Creation of uniform standards for quality assurance and improvement systems and recognition of private sector accredititation based upon comparable criteria can avoid such duplicative review, promote national uniformity and build upon private sector capabilities to modify accreditation criteria as advances occur.

Proposed Standards:

1. Any health plan offering covered services that must or may be obtained from participating providers must administer an internal quality assurance and quality improvement program that either:

   a. meets the following standards:

      (1) is clearly identified and fully explained to all participants in the program;
      (2) is coordinated with other medical management activities;
      (3) communicates findings to providers and consumers with the primary goal of improving care outcomes;
      (4) measures the impact of such findings on the care delivered by providers;
      (5) documents the monitoring and evaluation of the quality of care to identify areas for improvement;
      (6) develops and implements explicit strategies to improve care;
      (7) collects and analyzes data to facilitate evaluation of improvement strategies;
      (8) measures the effect of such strategies on care outcomes and the quality of care;
      (9) incorporates a credentialing process that encompasses initial credentialing, recredentialing, recertifying and/or reappointment of providers;
      (10) is accountable directly to the governing body of the health plan or, in instances in which the governing body's participation in quality assurance activities is not direct, to a designated committee of senior management; or

   b. is accredited by an independent organization, such as the National Committee for Quality Assurance, that conducts objective quality reviews based upon comparable criteria.

   (*Note:* Additional standards that address areas of special concern to the Medicare and Medicaid populations must be developed through a private/public sector partnership in order to take advantage of ongoing improvements in private sector quality improvement programs.)

2. Within a specified time after enactment of reform legislation, all health plans must develop the capacity to report on an annual basis the plan's performance in a manner that permits comparison with the performance of other health plans similarly configured and offering similar coverage. Such reports must be based on the most recent version of the Health Plan Employer Data and Information Set (HEDIS), with respect to both the standard measurements and the areas specified by HEDIS which include:

   a. quality
   b. access and patient satisfaction
   c. membership and utilization

d. finance
e. health plan management activities

Improvements in performance measurement must be incorporated into the criteria as they become generally accepted and available, and health plans must have a process for incorporating such improvements into their systems. (Additional criteria appropriate for Medicare and Medicaid populations that are consistent with the criteria applied to the private sector must be developed through a private/public sector partnership.)

CONFIDENTIALITY

The confidentiality of the clinician-patient relationship must remain inviolable, and consumers have every right to assume that information about the health care services they receive will remain private. Given the need to collect and analyze large volumes of data for the purpose of assessing the quality and cost-effectiveness of care, effective privacy safeguards take on even greater importance.

Proposed Standard:

All health plans must establish, maintain, and periodically review procedures to protect the confidentiality of patient information pursuant to applicable law.

MARKET CONDUCT REQUIREMENTS

In a reformed health care marketplace in which consumers will be choosing from among plans which have varying rules for obtaining services from participating and non-participating providers, it will be particularly important that all health plans observe fair marketing practices and that all promotional materials provide clear information about cost-sharing and procedures for obtaining covered services.

Proposed Standards:

1. All health plans must provide written descriptions of their benefits, services, and procedures that clearly and fully describe any and all limitations of coverage, exclusions, and out-of-pocket costs, including copayments, deductibles, co-insurance, and established aggregate maximums on out-of-pocket costs.

2. All advertising, promotional materials, and other communications with health plan members and/or the public must be and factually accurate and must be responsive to the needs of diverse populations.

ADMINISTRATIVE STANDARDS

Although increased choice will be inherent in a reformed health care marketplace, all health plans should also be committed to the principle of periodic consumer choice among HMOs and other health plans, including those offering indemnity coverage of services obtained from unaffiliated providers. In order for enrollees to be able to take full advantage of the coverage option they select, all health plans should have the administrative capability to provide clear information about the nature and extent of covered services and the procedures for obtaining services. Established internal dispute-resolution procedures should be available to enrollees, when disputes arise between health plans and enrollees.

Similarly, health plans should ensure that participating physicians and other clinicians are fully informed of the nature and extent of covered services and of plan rules for providing covered services to enrollees. Only well-informed physicians and other clinicians and well-informed consumers can make optimal use of available coverage. In addition, physicians should be afforded the means to have a voice in the development of policies that affect them and their clinical practices.

Proposed Standards:

1. All health plans must effectively communicate their administrative procedures to participating physician, other clinicians and facilities and to enrollees.

2. All health plans must establish procedures to gather input from enrollees on the nature and extent of covered services and the procedures for obtaining covered services.

3. All health plans must provide meaningful internal procedures for reviewing and resolving enrollee gnevances.

4. All health plans providing covered services through participating physicians must must have effective mechanisms for appropnate participation by those physicians in policymaking affecting patient care.

CAPITALIZATION STANDARDS

For health care reform to succeed, it will be critically important to establish criteria that maximize the likelihood that health plans will have the financial capability to provide promised health care benefits. Consumers must have confidence in the viability of the health plan serving them and must be protected against interruptions in continuity of care due to the failure of a plan offering covered services through its own delivery system, as well as against interruptions in coverage.

Due to the wide range of coverage options anticipated under health care reform, it is essential that capitalization standards address the full spectrum of these offerings, including traditional HMO coverage, traditional indemnity coverage and offerings that combine both HMO and indemnity features. For the purpose of establishing such standards, the most important difference among these coverages is the variation in the risk that their expenditures will differ from anticipated levels.

The NAIC Model HMO Act offers an approach that focuses on this distinction. For example, it reduces capitalization requirements where a health plan capitates providers. In this context, capitation must be interpreted to mean capitation of providers who in turn pursue strategies to promote high quality cost effective health care delivery, such as quality assurance and improvement programs and utilization review.

GHAA proposes modifying the Model Act to impose higher capitalization requirements based upon the extent to which health care expenditures are made for services obtained from nonparticipating providers on a self-referral basis. The underlying premise is that as total health care expenditures involve a smaller amount of capitated expenditures and an increasing amount of claims based expenditures for services obtained from out-of-plan providers on a self-referral basis, expenditures become less predictable and higher surplus requirements are appropriate. With respect to this standard, as well as those currently included in the NAIC Model Act, both the nature of the expenditure and the presence of delivery system characteristics that promote both quality and cost effectiveness are of importance in determining the level of the ongoing net worth requirements.

GHAA proposes the following standards as a starting point. We intend to continue to refine these requirements as the health care debate moves forward.

Proposed Standards:

1. As a condition of participating in the reformed health care marketplace, all health plans must be required to provide evidence of adequate capitalization and other indicators of fiscal health, including:

   a. Total assets greater than total unsubordinated liabilities;
   b. Sufficient cash flow and adequate liquidity to meet obligations as they become due;
   c. An insolvency protection plan; and
   d. Insurance or other acceptable arrangements to protect the health plan against liability and casualty risks, including professional liability.

2. When they commence operations, all health plans must be required to deposit with the state sufficient earnest money to demonstrate a good faith commitment to become an established provider of comprehensive health benefits coverage.
   (*Note:* The $300,000 initial deposit requirement in the National Association of Insurance Commissioners Model HMO Act will serve this purpose without creating an unreasonable barrier to marketplace entry.)

3. All health plans must be required to meet appropriate net worth requirements (which must be applied after accounting for all accrued expenses) in order to demonstrate that their operations are adequately capitalized on an ongoing basis. Plans must be able to demonstrate initial net worth of at least $1,500,000 (an amount which includes the $300,000 set aside for the initial deposit), and must be able to demonstrate operating net worth at least equal to the sum of (a) and (b) below:

   a. The greater of (1) $1,000,000; or (2) 2% of annual premium revenues on the first $150,000,000 of premium and 1% of annual premium on the premium in excess of $150,000,000; or (3) an amount equal to the sum of 8% of total health care expenditures on the first $150,000,000 and 4% of total health care expenditures in excess of $150,000,000 (except those paid on a capitated basis or on a managed hospital payment basis or those expenditures made for self-referred non-emergency services) plus 4% of annual hospital expenditures (paid on a managed hospital payment basis);
   b. An amount equal to the sum of 15% of health care expenditures up to $50,000,000 for self-referred non-emergency services and 8% of health care expenditures for such services in excess of $50,000,000.

   (*Note:* As indicated above, these standards are based upon the NAIC Model HMO Act. However, they have been modified to broaden their applicability to a wider range of coverages than originally contemplated, and in this form can be appropriately applied to the full spectrum of health plans, including those that combine managed care and indemnity insurance features. With the similar goal of creating 'seamless' regulation of all types of health plans, the NAIC is currently developing risk based capital standards which can be added to existing capitalization requirements. This approach will require careful review, since currently available risk based capital factors are not necessarily appropriate for all health plans, and new factors are being explored.)

PARENTAL GUARANTEES

For health plans that are owned or controlled by other entities, parental guarantees can be an effective mechanism to ensure fiscal soundness and provide insolvency protection.

Proposed Standards:

1. In order for the health plan or the legal entity of which the health plan is a part to use an organization as a guarantor of fiscal soundness, that organization must be a legal entity which:

   a. agrees to submit to the jurisdiction of the state for purposes of enforcing the guarantee;
   b. owns or controls, directly or indirectly, the majority of voting power in or is under common control with the health plan or the legal entity of which the health plan is a part; and
   c. has a net worth, including land, buildings, and equipment legally available to be pledged to cover operating expenses, equal to the greatest of the following:
      (1) $5 million; or
      (2) net worth in an amount needed to bring the health plan's net worth to the amount required to meet the net worth test and to assure sufficient cash flow and adequate liquidity to meet current obligations.

2. To ensure insolvency protection, only the greater part of 1(c)(1) or 1(c)(2) must be met.

3. The guarantor must have adequate financial resources to meet its obligations for all health plans whose fiscal soundness and/or solvency it guarantees.

PROTECTION OF CONSUMERS IN THE EVENT OF INSOLVENCY

Given the challenges and complexities of the health care marketplace, it is inevitable that some health plans will not succeed. Accordingly, statutory and regulatory protections should be established to ensure that consumers covered by a health plan that becomes insolvent are protected from incurring liability for the plan's legal obligations and that they are able to obtain uninterrupted coverage under another plan.

Proposed Standards:

1. As a matter of federal law (and as incorporated in the President's proposed legislation), all enrollees must be held harmless from incurring liability for the payment of any fees that are the legal obligation of the health plan.

2. To assure the availability to consumers of uninterrupted coverage under another health plan, all health plans offering coverage to the same pool of purchasers (e.g., within an alliance or other purchasing arrangement created under health care reform) must agree to accept enrollment of enrollees of an insolvent plan that had been offering coverage in the same marketplace, subject to capacity limits.

3. All health plans must make arrangements satisfactory to the state to satisfy obligations incurred prior to insolvency (including compliance with net worth requirements, insurance, reinsurance, insolvency reserves and other reasonable arrangements).

GUARANTY FUNDS

President Clinton's health care reform proposal would require each participating state to establish a guaranty fund "in order to provide financial protection to health care providers and others in case of a failure of a regional alliance health plan." Each participating regional alliance health plan would be assessed up to 2 percent of premium revenue to cover the outstanding obligations of an insolvent health plan. However, if consumer protections, such as statutory hold-harmless provisions, ensure that consumers will have continuity of coverage and suffer no financial harm as the result of a plan's insolvency, should guaranty funds still be retained as a mechanism to protect the financial well-being of providers?

GHAA is opposed to the concept of guaranty funds as mechanisms to protect health care providers. Effective enforcement of the initial deposit and net worth standards that we are proposing will mitigate against financial failure; in the event of the insolvency of a health plan, the requirements for an initial deposit and arrangements to satisfy obligations incurred prior to insolvency (such as reinsurance and insolvency reserves) will provide sufficient funds to meet the remaining responsibilities of the plan.

We believe that establishing guaranty funds primarily to indemnify providers will not only disadvantage sound health plans by adding to their costs, but will undermine one of the major building blocks of reform: modification of the behavior of providers to deliver high quality health care services in a more cost-effective manner. Achievement of this objective will be essential if competition among health plans is to be based upon quality and cost-effectiveness, and should not be jeopardized by creating guaranty funds to protect providers rather than consumers.

PREEMPTION OF RESTRICTIVE STATE LAWS

In many states, laws have been enacted that restrict the development of HMOs and other organizations that seek to provide health services through participating providers. For example, state laws requiring managed care organizations to contract with 'any willing provider' prevent plans from contracting selectively with providers. These laws strike at a core concept of HMOs and other managed care plans: their ability to create and manage provider networks best suited to the needs of the plan and its enrollees. The same problem is created by laws mandating the inclusion of specified types of providers in such plans.

Similarly, there are many state laws governing utilization review which, although generally intended to govern the conduct of freestanding utilization-review organizations, may also apply to, and interfere with, the internal utilization-review activities of HMOs and other managed care plans. In such cases, these laws unnecessarily encumber the utilization-review process rather than enhancing consumer protection. HMOs and other managed care plans are also subject to a variety of duplicative and/or inconsistent state and federal audit, data and quality assurance standards. Many states also require health plans to provide certain mandated benefits that are inconsistent with the national goal of requiring plans to compete on the basis of a uniform, consistent, comprehensive benefits package. State statutory prohibitions against the corporate practice of medicine should also be preempted.

Clearly, states have important roles to play in implementing and overseeing health care reform. To encourage innovation and experimentation, regulatory flexibility is desirable. Only uniform national standards, however, can create a truly level playing field on which managed-care and fee-for-service options compete on the same basis of quality, service, and cost-effectiveness nationwide.

Proposed Solution:

State 'any willing provider' and mandated provider laws which restrict the freedom of health plans to design provider networks best suited to the needs of their enrollees must be preempted by federal law, and other state laws that are inconsistent with the goals of national health care reform must also be preempted. Such state laws include:

- those that mandate benefits inconsistent with the establishment of a uniform comprehensive benefits package;
- those that create standards in areas such as capitalization, solvency, and quality assurance that will be the subject of federal requirements;
- laws that restrict use "gatekeeper" mechanisms;
- laws that ease anti-trust prohibitions applicable to providers or that permit formation of provider bargaining units without requiring the sharing of material economic risk by the persons/entities doing the bargaining;
- laws that expressly permit providers to form health plans that assume risk but that do not have to meet the capitalization requirements applicable to non-provider sponsored plans; and
- those that would interfere with the goal of consistent regulation by establishing different standards for different plans based on the structure of the plan.

Statement of

Family Health Plan Cooperative

Family Health Plan Cooperative appreciates the opportunity to present this response to testimony given before you Thursday, February 3, by Karin Smith, a member of Family Health Plan Cooperative. Since Ms. Smith remains a member of our health plan, we cannot disclose information specific to her condition or treatment. We can, however, present information on a past relationship with a former lab which led to the problems described by Ms. Smith.

Karin Smith has suffered a terrible tragedy. But while Ms. Smith places the blame for her condition squarely with her HMO, this is, much more than anything else, the story of a single lab which lacked adequate quality controls, despite its Medicare certification and accreditation from the American College of Pathologists.

Family Health Plan is a nonprofit, staff-model HMO. We provide affordable, quality care on a prepaid basis to 109,000 Medicaid and Medicare beneficiaries, individuals and group members. We employ 77 primary care physicians and operate six health centers. By efficiently providing care and controlling costs, we are able to offer comprehensive coverage to such a diverse segment of our community.

Our family-practice model of care emphasizes primary care and prevention of illness through comprehensive check-ups, mammograms, immunizations for kids and adults, prenatal risk assessment and care, health education and more--all covered 100 percent in the vast majority of programs we offer. Our physicians are board certified or board eligible, and our organization is federally qualified and accredited by the Accreditation Association for Ambulatory Health Care.

As a consumer cooperative, Family Health Plan seeks to "give the health consumer a voice and some control in the operations of the health care delivery system." The consumers of Family Health Plan, our members, directly elect the plan's board of directors, which features plan members. In each Family Health Plan facility, member advocates assist in providing information and helping members with concerns or questions. These advocates are the entry point to a process for addressing member complaints and grievances which meets the requirements set by state HMO

regulators as well as the federal government for purposes of federal qualification.

Members of Family Health Plan Cooperative select a primary physician for themselves and their families. They can change physicians and health centers at any time. Family Health Plan contracts with 200 specialist providers. In some cases, the specialist providers contract to serve one region of Family Health Plan's service area. This provides the greatest opportunity to ensure that members receive timely access to specialty services. Members from one region who refuse to see a specialist from their region may address their concerns with Family Health Plan's Benefits Review Committee.

Consistent with cooperative principles, the directors of the plan have always represented a cross-section of our community. One of the first directors of Family Health Plan was a principal in a local independent cytology laboratory.

While on the HMO board, this director was intentionally excluded from lab-contracting matters to avoid a conflict of interest. That director left the board of Family Health Plan in 1987.

Competitive bidding is part of every industry, including health care. But price is not the only determinant of the winning bidder. Quality and service are equally important, as we seek the highest quality, most cost-effective services for our members. Up through the last term of the contract between the cytology lab and Family Health Plan, very few laboratory standards were in place for the screening of pap smears and biopsies. This was prior to enactment of regulations implementing the Clinical Laboratory Improvement Act of 1988 (CLIA). Family Health Plan relied upon the lab's status as a Medicare-certified lab, accredited by the American College of Pathologists, as well as an independent audit conducted with assistance from the Wisconsin State Lab of Hygiene for proof of quality.

Family Health Plan terminated its contract with the lab in 1991 for service reasons, despite a lower financial bid from the lab. Months later, Family Health Plan learned of quality problems at the lab and subsequently participated in a massive effort to identify patients, such as Ms. Smith, who may have been victimized. But Family Health Plan was only one of several customers of this lab. Many other patients were effected by the situation at the lab.

For about a year and a half after that, Family Health Plan operated a cytology lab in one of our own health centers. All Pap smears from Family Health Plan members were read at this lab, which was set up with quality controls beyond those called for in CLIA. Family Health Plan offered employment to an experienced cytotechnologist to supervise the lab. Later, we learned that this cytotechnologist was allegedly implicated in the quality problems at the former cytology lab.

After learning that a problem might exist, we followed up on the information we had to determine the potential for problems in Family Health Plan's new lab. Our supervising, board-certified pathologists, the state of Wisconsin and independent testing confirmed that the work performed at our in-house lab was of good quality. Later, Family Health Plan voluntarily undertook another, comprehensive retesting effort. We rechecked more than 10,000 Pap tests, just to provide extra assurance to our members that their health plan was providing quality care and services.

Family Health Plan was one of twelve defendants in a lawsuit brought by Ms. Smith. All defendants contributed to a settlement of $6.3 million, with Family Health Plan as a minority participant. The primary interests for Family Health Plan were seeing that Ms. Smith received the care she needed and returning our full attention to providing care and services to our members.

Family Health Plan no longer has a relationship with the former lab or any other provider named in the lawsuit brought by Karin Smith. She voluntarily remains a member of Family Health Plan and continues under our care.

It may be useful to consider the tragic experience of Karin Smith in the context of health care reform. But recognition must be given to the facts of this case, as well as the fact that HMOs have repeatedly been found to provide care that is as good or better than the care provided under traditional, fee-for-service arrangements. At the same time, HMOs have shown they can control costs while maintaining quality of care better than non-organized systems. Quality and cost must be considered together.

The lesson learned from our recent experience with a troubled lab is that quality guidelines and controls in health care need to be established and followed. An organized system of prepaid health care can provide assurance of such controls, as ours did in our own in-house cytology lab.

Please feel free to direct comments or questions to Family Health Plan Cooperative, Attn: Philip Dougherty, Public Affairs, 11524 W. Theodore Trecker Way, Milwaukee, WI, 53214.

Arizona Health Care Cost Containment System

To the Subcommittee on Labor:

It is unfortunate whenever a member of the Arizona Health Care Cost Containment System has a negative experience with Arizona's Medicaid program. We admit that in a system of more than 465,000 members, problems may and do arise. We endeavor, however, to provide high quality, accessible care to all our members and we work hard to maintain that level of care. It is untrue that the system is set up to deny coverage to applicants. In recent years, independent studies, including press investigations, have shown that dissatisfaction with AHCCCS services is by far the exception and that quality of care is high.

Because of confidentiality, and because we do not have permission from the client to discuss particulars of this case, we cannot go into specifics. But we can address the more general accusations. Before we do this, however, you should know that unlike traditional fee-for-service Medicaid programs, AHCCCS contracts with health plans in the private sector for the care of its members in a managed-care setting. This partnership between state government and the private sector is what allows AHCCCS to mainstream its members into the same medical facilities used by private-pay individuals, and thus offer a higher quality of care. More than 70 percent of the physicians in Arizona are registered as AHCCCS providers.

It is true that AHCCCS does not cover liver transplants for adults. This restriction, however, is not a rule originated by AHCCCS, but a state law that allows these transplants only for members under age 21 who enter the program through categories that are federally funded. We cannot expand this service without legislative approval. The legislatures of the different states have latitude, within broad federal guidelines, to offer or restrict certain medical coverage. A restriction such as ours, however, is not a flaw of managed care but rather a reality of legislative priorities based on available tax dollars.

It is not true that the system is set up to deny care, regardless of what an eligibility worker might have said. Eligibility people are not AHCCCS employees, but work for county, state or federal offices where the various categories of AHCCCS members are made eligible. We do, however, acknowledge that our eligibility process is complex and difficult to understand, partly because of numerous regulations at the federal level. It has long been our goal to streamline this process and make it easier for clients to enter the system.

It is also untrue that program costs have increased astronomically. Currently we are operating under a total budget of about $1.6 billion. Last year it was $1.4 billion. The year before it was $1.2 billion. The increases are due to inflation, a growing population and the addition of some new programs. A recent study by Laguna Research Associates shows that from Fiscal Year 1983 through Fiscal year 1992, AHCCCS acute care costs increased 69 percent while those of a traditional Medicaid program increased 113 percent. Other studies, specifically one by SRI International and another by the Flinn Foundation in Phoenix, show that quality of care is as good or better than comparison states, and that satisfaction with the program is very high. All of these studies are available for review. In addition, over the past two years major media outlets such as the New York Times, U.S. News & World Report and Good Morning America have investigated AHCCCS and found the same level of satisfaction and quality of care, and a recent Gallup Poll shows that Arizonans place a high priority on maintaining the current AHCCCS program.

Our contracting health plans are required to have member service departments to deal with any member problems, and these departments are part of annual programmatic reviews. The plans also must have grievance policies and procedures for members who continue to have questions or problems. In addition, a client advocate office within the AHCCCS administration investigates and resolves member problems that are not resolved at the health plan level. The case of Ms. Penny Puhl was not brought to the administration's attention until late 1993, after she had moved to Illinois.

The AHCCCS program, like any other Medicaid system, is a complicated one. We certainly sympathize with members experiencing difficulties, and we encourage them to make their concerns known at the health plan level or at the administration level so we can work to correct misunderstandings or actual problems. Even so, with a system this large, unfortunate experiences can occur. We wish we could eliminate all of them. Overall, however, the preponderance of good experience has shown us that we can deliver better quality care through a managed care approach. We are dedicated to continue delivering this care using our managed care system.

Maricopa Managed Care Systems

To Subcommittee on Labor:

Maricopa Managed Care Systems is a department of Maricopa County government operating several prepaid, managed health care plans including a Medicaid Plan called Maricopa County Health Plan. In this capacity, Maricopa Managed Care Systems contracts with the Arizona Health Care Cost Containment System (AHCCCS). AHCCCS is the State of Arizona's demonstration Title XIX program. AHCCCS has provided health care for the needy for over ten years in Arizona. The state program now serves more than 459,000 people. Maricopa Managed Care Systems participates in the AHCCCS program through a competitive bid, prepaid capitated contract.

Maricopa Managed Care Systems provides a comprehensive and coordinated patient care system through a County hospital and 14 County operated primary care centers. Our mission is to protect, preserve and improve the physical, behavioral and environmental health of our members, with a special responsibility to serve those most vulnerable.

The total membership of Maricopa Managed Care Systems is 52,029, of whom 44,603 are served under the Maricopa County Health Plan. In addition to quality care, customer satisfaction is of critical importance. Of our clients randomly surveyed by an outside agency in 1991, 96% indicated agreement that they received good care in our managed care system. Our quarterly surveys provide us with an on-going system of feedback, targeting improvement in our primary care service system. These primary care centers are staffed with approximately 40 physicians and 15 midlevel practitioners. Clients may be assigned to various AHCCCS plans if during open enrollment they do not choose a plan. Within the Maricopa County Health Plan, members may choose any clinic or primary care physician available and may change physicians at any time. When scheduling appointments, members are never restricted to a nurse practitioner.

Arizona Revised Statutes (A.R.S. 36-2907.A.11) and State regulations declare adult liver transplants are not a required medical service that the state must fund under the Medicaid program. AHCCCS does not approve liver transplants for adults except by court order. Maricopa Managed Care Systems, by statute and through contract, is not required to include liver transplants as a covered service. In addition, there are no Medicare certified liver transplant centers in the state of Arizona.

Maricopa Managed Care Systems is dedicated to providing members quality care. While we constantly seek to improve our care system and the satisfaction of our members, we know that we provide excellent preventive and treatment services within the benefit package defined by the State of Arizona for its Medicaid enrollees.

Statement of

Laurence Bouchard, D.O.

President

American Osteopathic Association

Thank you, Mr. Chairman, for inviting me to testify on health care reform. My name is Laurence Bouchard and I am an osteopathic physician who has practiced in family medicine in Narragansett, Rhode Island for the past 31 years. I come before you today as the President of the American Osteopathic Association (AOA). With me is Douglas Ward, Ph.D., Associate Executive Director for Education of the Association.

I would like to begin by establishing the framework for debate of the health care delivery system. That is - As the nation debates how best to deliver health care to the patients of this nation, I believe we must remember the patients. With or without health care reform, the needs of the patients do not change.

We as osteopathic physicians agree that reform is indeed needed. For reform to be effective however, patients must be able to choose the physician of their choice, including osteopathic physicians. This freedom of choice can only be guaranteed if federal statutory language is written: 1) to protect the role of osteopathic physicians under current and future health care delivery mechanisms; and, 2) to ensure the continued viability of the osteopathic education training model.

The Osteopathic profession is no stranger to reform. We began as a reform movement. Andrew Taylor Still, MD, was dissatisfied with the effectiveness of 19th century medicine and began our profession over 100 years ago. He founded a philosophy of medicine which focuses on the unity of all body parts and the body's innate ability to heal itself.
The American Osteopathic Association is the national professional organization representing the nation's 35,000 osteopathic physicians who have chosen to learn, teach and practice Dr. Still's philosophy. Doctors of Osteopathy (D.O.s) practice in all medical specialties, but the

overwhelming majority are primary care/generalist physicians who provide a complete range of services to patients of all ages. Despite the fact that osteopathic physicians constitute only 5.5 percent of the Nation's physician-manpower, they are often the only physicians in rural and underserved areas, and we are proud of that. Osteopathic physicians in fact comprise more than 15 percent of all physicians practicing in communities with populations of less than 10,000 people and 18 percent of all physicians serving communities of 2500 or less.

In addition, according to the U.S. Department of Health and Human Services, osteopathic physicians serve approximately one out of every seven Medicare and 25 percent of all Medicaid recipients in the United States. Osteopathic physicians also comprise 10 percent of all physicians serving in the military. In all, over 100 million patient visits are made to osteopathic physicians annually.

The osteopathic story has been written by the patients, who by their demand for osteopathic services, have carved a vital niche for osteopathic medicine in today's health care delivery system. To continue to meet this demand, the osteopathic profession recognizes the need for reform of the current health care delivery system. This reform must include a global budget for national health care expenditures to reduce cost-shifting among the public and private payors, and to control the rising health care portion of the GDP.

Once a target is established, a uniform basic package of benefits, which includes coverage of preventive care must and can be developed and made available to all Americans. As a profession which was born based on the belief that the body has the intrinsic ability to heal itself, the AOA wholeheartedly supports a greater reliance on preventive and primary care.

Once a basic benefits package is developed, a method on how best to deliver these benefits must be determined. The AOA believes that a model which provides enough competition to promote efficient health care delivery without sacrificing quality health care is the best method to address the competing objectives of reducing costs while preserving quality. To

that end the profession supports a delivery system based on managed competition - that is, an integrated system of financing and delivering health care through several types of health plans. President Clinton's proposed system of alliances presents a good point from which debate on delivery mechanisms should start.

Under a system of managed competition, or any other delivery system, however, patients should be able to receive care from the professional of their choice. Hence, any delivery system must provide the opportunity for all qualified physicians to participate. Criteria to determine who is qualified should not be based on degree granted or the organization which approves the graduate training programs or awards the certification. Rather, physicians should be judged on their ability to provide quality care at an appropriate cost. For example, osteopathic physicians hold a degree as a Doctor of Osteopathy (D.O.), pursue training in osteopathic postgraduate training programs, and become certified approved through osteopathic certification examinations. Although these valuative indicators are considered equal to similar allopathic indicators, many private payors are ignorant of this separate process. Consequently, patients around the nation today are being denied access to the provider of their choice -the osteopathic physician- because the private payer has not taken the time to understand the differences and the benefits that the osteopathic physician can bring to the patients.

It is because of this situation, that the AOA is before you today. In order for patients to truly have freedom of choice of provider, Congress must enact legislation which prohibits private insurers and delivery mechanisms from discriminating based on degree, postgraduate training and certification.

Congress also must act to protect the medical training programs which train individuals to provide appropriate care to the patient. The osteopathic profession is extremely proud of its unique educational model, which produces physicians who provide excellent primary and specialty care. As a matter of fact, the profession believes that it has the model program

BOSTON PUBLIC LIBRARY
3 9999 05982 595 8

to achieve the appropriate national balance between primary and specialty physicians. This model has produced over 60 percent primary care physicians among all osteopathic physicians delivering care today, which is well in compliance with the federal initiative. Included in this model is a rotating internship which trains osteopathic physicians in generalist practice first and after which practically all choose to receive additional training whether it be in primary care or specialty residency programs. These internships and residencies are directed by both osteopathic primary care and specialty physicians. In order to retain this very successful training model, osteopathic training programs must be protected.

The AOA has worked very closely with both congressional advisory bodies of COGME and PPRC to advance the osteopathic training model. Both bodies understand well the contribution of osteopathic medicine. In an effort to address the aggregate number of training slots, however, both bodies also have recommended that the total funded residency positions be limited to the number of osteopathic and allopathic medical school graduates together plus 10 percent. Because of our smallness and community - based approach to teaching, the profession is very concerned that osteopathic programs could be absorbed if integrated rather than kept separate from the larger allopathic numbers. To prevent this from happening and to continue to provide patients with osteopathically trained physicians, the AOA is requesting that its programs be treated separately. That is, the osteopathic internship which is a requirement of all osteopathic trainees be additionally included in the eligible years of postgraduate training. Further, the total funded osteopathic first year residency positions should be limited to the number of osteopathic medical school graduates plus 10 percent while separately, the total funded allopathic residency positions should be limited to the number of allopathic medical school graduates plus 10 percent.

Mr. Chairman and Members of this distinguished Subcommittee, I hope that in this short time I have increased your awareness of osteopathic medicine and its unique and vital contribution to health care delivery in this nation. Additional details about my comments can be found in the written statement. In summary, though, the AOA is a balanced profession offering a majority of primary care physicians and an appropriate number of

specialists. We believe that a health care crisis does indeed exist and as such support a global budget for health expenditures, a basic benefits package which includes primary and preventive care, and a delivery system based on managed competition.

We know that this crisis will only worsen if osteopathic physicians are prevented from delivering care because of the unique degree, training and certification they possess. Further, there will be no osteopathic physicians in the future if an appropriate number of our training programs are not recognized and funded.

Mr. Chairman that concludes my remarks. I would be happy to answer any questions of the Subcommittee.

[Whereupon, at 11:37 a.m., the subcommittee was adjourned.]

O

81-706 (176)

ISBN 0-16-044764-X

90000

9 780160 447648